

Putting Patients First



Annual Plan 2012/13

For presentation to the Trust Board on 31 May 2012

Putting Patients First



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Putting Patients First



Section 1: Introduction



The NHS is facing an unprecedented period of both opportunity and challenge. Our patients quite rightly expect the highest standards of dignified care, using the latest available treatments and technologies in ways that are convenient, timely and accessible. Alongside this, the current economic climate has a significant impact on the resources available to us – as individuals and families, as an NHS, as the broader public sector.

Tough times need creative solutions. The NHS therefore has the opportunity to create new ways of providing care that both exceed our expectations and offer better value for money for the public purse. For example, by getting better at assessing and treating venous thromboembolism we reduce complications for patients, which reduces length of stay in hospital and ongoing treatment and discomfort, and in turn this is more cost effective. By adopting the latest procedures, more patients can have their treatment as a day case, return home promptly and resume their normal life as early as possible. By reducing unnecessary delays for patients admitted to hospital as an emergency we can improve their recovery and reduce the risks associated with a stay in hospital. Importantly, by doing more to prevent a hospital admission in the first place we can help people to maintain their independence and resilience.

Not only do these improvements make care better for patients, they also mean that we can do more for patients with fewer resources. This is what we need to do more of to make sure all of us continue to have a safe and affordable NHS for the future.

During 2011/12 we made progress in all of these areas in The Shrewsbury and Telford Hospital NHS Trust. Looking ahead we will need to do even more in order to maintain high standards of care whilst saving about five pence in every pound in each of the next two years.

Major priorities for the year ahead will include completion of the Lingen Davies Cancer Centre, work to replace one of our linear accelerators which provide vital radiotherapy treatment for people with cancer, the start of building work for our new women and children's facilities at the Princess Royal Hospital, the establishment of Royal Shrewsbury Hospital as our main centre for inpatient acute surgery, and the roll out of a new life-saving screening programme for abdominal aortic aneurysms.

We will also be continuing with our journey to NHS Foundation Trust status by 2014. All NHS Trusts must become Foundation Trusts or they face being split up or taken over. We believe that that best future for local hospital services is to retain our local independence as a Foundation Trust, with public governors from Shropshire, Telford & Wrekin and mid Wales taking a central role in

shaping local health services. We will continue to ensure safe and sustainable hospital services through development and reconfiguration, including by strengthening our focus on rural health, integrated care and telehealth. Most importantly, we will continue to focus on our central organising principle of Putting Patients First in designing what we do.

Our central organising principle is "**Putting Patients First**". This simple phrase should guide every decision we make in our hospitals, making us think about what really matters so that we use our time, skills and other resources to the best of our ability so that we can afford to do more for patients. Importantly our decisions must be made in the knowledge that the income we receive as a Trust is declining in real terms.

This means delivering:

- **Safe Care:** Putting Patients First by ensuring that we deliver the highest standards of patient safety and patient experience.
- **Timely Care:** Putting Patients First by making sure that we achieve and maintain waiting time standards in A&E, outpatient, inpatient, day case and cancer care
- **Affordable Care:** Putting Patients First by making sure that we live within our means, do not spend more than the resources available to us and are able to invest in quality for the future.

The vision we have set for this organisation is to be **ambitious about changing healthcare for the better**. We want to be the best at helping patients receive the care they need, where and when they need it. We have therefore set out to build a future where we can afford the kind of quality of service that we all aspire to. It is our view that in order to face respond to the financial challenge whilst meeting the expectations of our patients we must work together – health and social care organisations, the voluntary sector, the independent sector, patients and communities to develop and deliver a transformation of the local health system. For example, the NHS should place less reliance on less reliance on acute hospital care and shift the focus to a service that supports and sustains people in their own homes or as close to home as possible

This Annual Plan therefore sets out how the Trust will develop, enhance and change in the context of the challenges facing the Trust to ensure that we deliver services for which we can all be truly proud of.

Putting Patients First



Section 2: Profile

- 2.1 Overview
- 2.2 Range of Services
- 2.3 Activity

2.1 Trust Overview

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin and mid Wales. We were established in 2003 following the merger of The Princess Royal Hospital NHS Trust and the Royal Shrewsbury Hospitals NHS Trust.

2.1.1 Our main service locations

Our main service locations are the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury, which together provide 99% of our activity. We also provide community and outreach services such as:

- Consultant-led outreach clinics at Wrekin Community Clinic in Telford, Robert Jones and Agnes Hunt Orthopaedic and District Hospital (RJAH), Bishops Castle, Bridgnorth, Ludlow, Whitchurch, Newtown and Welshpool community hospitals.
- Midwife-led units at Ludlow, Bridgnorth and Robert Jones and Agnes Hunt Orthopaedic and District Hospital (RJAH).
- Community midwifery services across Shropshire and Telford & Wrekin.

Information about our main service locations is set out in Table 2.1a (as at 1 March 2012). Further information about our services and activity is provided in Section 2.2 and 2.3.

Table 2.1a Our main acute sites and midwife-led units		
Princess Royal Hospital (PRH)	Adult Inpatient (overnight) beds	275
	Children's inpatient and assessment beds	24
	Surgical day case beds	24
	Renal dialysis stations	20
	Chemotherapy/haematology day centre	10
	Intensive care / high dependency	11
	Midwifery-Led Unit beds	13
	PRH provides A&E, inpatient, outpatient and day case facilities for general and acute medicine, cardiology, general surgery, upper gastro-intestinal and breast surgery, urology, critical care, trauma and orthopaedic services, paediatric services, midwife-led maternity, emergency treatment and renal dialysis. A range of other specialities are provided as outpatient and daycase. PRH has a 10-bedded private patient facility and private outpatient service.	
	In future the PRH will be our main centre for inpatient women's and children's services.	
	Royal Shrewsbury Hospital (RSH)	Adult Inpatient (overnight) beds
Children's inpatient and assessment beds		23
Surgical day case beds		24
Renal dialysis stations		24
Chemotherapy/haematology day centre		16
Intensive care / high dependency		9
Consultant maternity beds		41
Midwifery-Led Unit beds		13
Neonatal Intensive Care Unit beds		6
Special care baby unit beds		16
RSH provides A&E, inpatient, outpatient and day case facilities for general and acute medicine, cardiology, general surgery, colorectal surgery, vascular surgery, urology, gynaecology, critical care, trauma and orthopaedic services, paediatric services (including oncology and head & neck), emergency treatment, oncology & haematology, renal, ophthalmology, oral & maxillofacial surgery and ENT, consultant and midwife-led maternity services (with co-located neonatal intensive care). In future the RSH will be our main centre for acute surgery.		
Bridgnorth	Midwifery-Led Unit beds	4
Ludlow	Midwifery-Led Unit beds	7
Oswestry	Midwifery-Led Unit beds	6

2.1.2 Our Workforce

In 2011/12 our workforce grew by 253 staff, bringing the number employed to 5390, Given that many of our staff work part-time this represents 4521 whole-time equivalent (wte). Expenditure on staff accounts for approximately 66% of our expenditure.

Our workforce at 31 March 2012 included:

- 513 wte doctors and dentists (11.3%)
- 1,366 wte nursing and midwifery staff (30.2%)
- 578 wte scientific, technical and therapies staff (12.8%)
- 1,213 wte other clinical staff (26.8%)
- 852 wte non-clinical staff (18.8%)

There are currently over 500 active volunteers in the Trust and we work closely with our main charitable partners (including Leagues of Friends at our two main hospitals, WRVS and the Lingen Davies Cancer Appeal).

2.1.3 Our Communities

Over 99% of our services are provided to patients from Shropshire, Telford & Wrekin and northern and eastern in Powys. Whilst most of Shropshire and Telford & Wrekin would see our hospitals as their main local acute hospital, our catchment in Wales includes around 60,000 people in Montgomeryshire and north east Radnorshire (of an overall Powys population of 131,300).

This area, encompassing around half a million people, extends from the sparsely populated Powys in the west, through rural Shropshire to urban Telford. The main population centres are Shrewsbury and the new town of Telford. Alongside these major towns the area contains numerous smaller market towns including Bridgnorth, Ludlow, Market Drayton, Newtown, Oswestry, Welshpool, Wem and Whitchurch.

The map and table on the right (Table 2.1b) summarise our catchment for our main hospital services.

Some of our specialist services, such as the Shropshire and Mid Wales Fertility Centre, attract patients from a larger catchment but this represents less than 1% of our overall activity.



Area	Powys	Shropshire	Telford & Wrekin
Population	131,300	293,400	162,600
Area	5,179	3,199	291
Population Density	25	92	556
Overview	Powys is the most sparsely populated county in England and Wales and there are no acute hospitals in the county. Around 60,000 people from north and east Powys (eastern Montgomeryshire and north east Radnorshire) look to us as their main provider of acute hospital care.	Shropshire is a predominantly rural county with a varied landscape. It is one of the most sparsely populated counties in England with a mix of the county town (Shrewsbury, which is home to the Royal Shrewsbury Hospital), small market towns and rural areas.	Telford & Wrekin is a small unitary authority dominated by the large new town of Telford (home to the Princess Royal Hospital), which is the largest population centre in our catchment and nearly twice the size of nearby Shrewsbury.
Key towns	Y Drenewydd (Newtown) and Y Trallwng (Welshpool)	Shrewsbury, Oswestry, Bridgnorth, Market Drayton, Ludlow, Whitchurch, Wem	Telford, Newport

2.1.4 Our turnover and income

Our annual turnover was just below £300m in 2011/12

The majority of our income (90%) is for clinical services and is primarily derived from our three main commissioners, namely Shropshire County Primary Care Trust, Telford & Wrekin Primary Care Trust and Powys Teaching Health Board. Our contracts represent the majority of acute services expenditure for Shropshire County (59%) and Telford & Wrekin (70%), but a significantly smaller proportion for Powys (9%) which is served by a ring of acute hospitals outside the county.

The remainder of our clinical income comes from small levels of activity from other commissioners, specialist service income (e.g. renal and neonatal services commissioned via West Midlands Specialised Commissioning and Health Commission Wales) as well as other clinical income (e.g. private and overseas patients, NHS Injury Cost Recovery Scheme).

The balance of our income (10%) is for non-clinical services such as Education.

Our total income in 2011/12 included £6.5m non-recurring funding from the Strategic Health Authority.

Table 2.1c Income 2009/10 to 2011/12			
Commissioner	2009/10 £000s	2010/11 £000s	2011/12 £000s
Clinical Income:			
Shropshire County PCT	115,186	121,449	132,401
Telford & Wrekin PCT	80,527	87,756	94,269
Powys Teaching Health Board	21,163	21,446	20,261
Other Clinical Income	22,040	21,240	24,199
Total Clinical Income	238,916	251,891	271,130
Non-Clinical Income:	23,967	21,089	28,720
Total Non-Clinical Income	23,967	21,089	28,720
Total Income	262,883	272,980	299,850

2.1.5 Our expenditure

Our annual expenditure for 2011/12 was just below £300m.

Table 2.1d Expenditure 2011/12			
	Plan	Actual	Variance
	£m	£m	£m
Pay Costs	(199.2)	(200.0)	(0.8)
Non Pay Costs	(76.8)	(85.2)	(8.4)
Sub Total	(276.0)	(285.2)	(9.2)
Finance Costs	(14.2)	(14.6)	(0.4)
Total Expenditure	(290.2)	(299.8)	(9.6)

The costs of pay and non pay exceeded the Trust plan by £9.6m. These additional costs have been funded through the additional income received. The increase in expenditure resulted from several factors including:

The reduction of the over 18 week backlog has required the Trust to put into place increased capacity within the two hospital sites and also to purchase external capacity, particularly in respect of Orthopaedic activity, from local external providers. This has led to an increase in pay costs to Clinical and Non Clinical staff. In addition to ensure the safe delivery of particularly Unscheduled Care the Trust has been required to put in place temporary staffing. Such staff attract a significant pay premium.

The increased usage of High Cost Drugs, particularly in the treatment of Cancer and Ophthalmology patients, has exceeded levels as specified within the local Health Economy. Such increased costs are recovered from the local commissioners. The actions taken to reduce waiting times has also increased non pay costs as the Trust has purchased substantial levels of additional theatre capacity from the local Nuffield Hospital.

2.1.6 Our organisational structure

We have a clinically led management structure with our clinical services delivered in 11 Clinical Centres, each led by a Consultant or other specialist (e.g. Pharmacist, Therapist). Alongside our Centres, we have four cross-cutting programmes, or Value Streams, to support improved patient care across the Trust and with our external partners. These cover cancer care, scheduled care, telehealthcare and unscheduled care and are each led by a Consultant.

Our Clinical Centres are supported by corporate functions led by our corporate directors:

- Chief Nurse / Director of Quality and Safety
- Communications Director
- Director of Business and Enterprise
- Director of Compliance and Risk Management
- Director of Operations
- Finance Director
- Medical Director
- Workforce Director

The main management decision-making body in the Trust is the Hospital Executive Committee, which is chaired by the Chief Executive and is a sub-committee of the Trust Board. The Hospital Executive Committee drives performance and delivery throughout the Trust and comprises the Centre Chiefs, Chief Executive and corporate directors.

Decisions in the Trust are made through **devolution** to frontline clinical services in the Clinical Centres and **cooperation** across the Trust to ensure a co-ordinated approach to quality and delivery. Centres have devolved accountability for managing their Centre budget, and mutual accountability for the Trust budget through the Hospital Executive Committee and other financial accountability and governance processes. .

2.2 Range of Services

The Trust offers a comprehensive range of acute services including:

- **Diagnostics (Diag)**, including: Pathology (Haematology; Blood Transfusion; Phlebotomy; Clinical Biochemistry; Microbiology; Histology; Cytology; Mortuary Service) and Radiology (Plain film; Ultrasound; CT; MRI; Nuclear Medicine).
- **Emergency and Critical Care (ECC)**, including: Accident and Emergency; Medical Assessment Units & Medical Admissions Ward / Acute Admissions; Intensive Therapy Unit and High Dependency Unit including Critical Care Outreach Team; Hospital at Night Nurse Practitioner Team; Clinical Site Management Team; Major Incident and Emergency Planning.
- **Head and Neck (H&N)**, including: Audiology; Ear, Nose and Throat (ENT) services; oral and maxillo-facial surgery; Orthodontics, restorative dentistry.
- **Medicine (Med)**, including: General Medicine; Geriatric Medicine; Respiratory; Diabetes & Endocrinology; Neurology; Dermatology; Stroke Medicine; Cardiology, Coronary Care Unit, Cardiorespiratory and Cardiac Rehabilitation; Renal.
- **Musculoskeletal (MSK)**, including: Trauma and Orthopaedics; Rheumatology; Osteoporosis; Pain Management.
- **Oncology (Onc)**, including: Clinical and medical oncology (including chemotherapy and radiotherapy); Palliative Care; Clinical haematology.
- **Ophthalmology and Patient Access (Oph)**, including: Ophthalmology and Orthoptics; Outpatients; Booking and Scheduling; Medical Records.
- **Pharmacy (Pharm)**, including Dispensing and Distribution; Medicines Management; Medicines Information and Utilisation; Aseptic Suite and Medicines Production.
- **Surgery (Surg)**, including: General surgery; Urology; Colorectal and Upper Gastrointestinal surgery; Gastroenterology; Vascular surgery; Breast Surgery; Paediatric Surgery; Anaesthesia (excluding critical care); Endoscopy; Theatres; Day case surgery; Apley Private Practice Unit; Pre-operative assessment; Sterile Services

- **Therapy (Ther)**, including: Physiotherapy; Occupational Therapy; Speech and Language Therapy; Dietetics.
- **Women's and Children's (W&C)**, including: Obstetrics and Midwifery; Paediatrics; Neonatology and special care baby services; Fertility Services; Gynaecology.

These services form the core of the mandatory services list which we will be submitted during the Monitor assessment phase.

During 2011/12 we saw:

- 56,301 elective and day case episodes (a 2.82%% decrease on 2010/11).
- 41,962 non-elective inpatient episodes (a 2.84% increase on 2010/11).
- 346,635 consultant-led outpatient appointments (a 7.64% increase on 2010/11).
- 110,425 accident and emergency attendances (a 3.85% increase on 2010/11).
- 6,746 maternity episodes (a 0.01% decrease on 2010/11).

During the course of the year there was a transfer of activity from day case episodes to consultant-led outpatient appointments (procedures). This was in line with changes in national definitions and rules.

More information about Trust-level activity can be found in Section 2.3. A breakdown of patient activity in our main patient specialities is set out below in Tables 2.2a and 2.2b

Table 2.2a Consultant-Led Patient Activity by Speciality				
Consultant-Led Patient Activity by Speciality				
Speciality	Inpatient/Daycase		Outpatient	
	2010/11	2011/12	2010/11	2011/12
ECC: A&E Outpatient	8	18	3,413	3,520
H&N: ENT	3,130	3,358	17,641	19,593
Oral and Maxillofacial	1,883	2,063	10,570	11,012
Orthodontics		0	11,150	10,137
Audiological Medicine		0	1,221	2,638
Med: Cardiology	1,824	2,135	11,998	13,015
Dermatology	15	35	12,992	14,536
General Medicine*	21,500	22,307	30,715	29,878
Neurology	220	313	8,341	8,414
Trauma and MSK: Orthopaedics	7,130	7,240	53,321	53,294
Pain Management	1,001	1,061	2,334	3,209
Rheumatology		0	1,860	1,167
Onc: Oncology	8,269	8,725	11,475	12,424
Haematology	4,786	5,499	9,184	9,862
Oph: Ophthalmology	7,971	4,047	35,180	47,936
Surg: Anaesthetics		0	767	272
Gastroenterology	13,510	14,760	8,977	9,882
General Surgery**	11,164	11,497	31,182	31,619
Neurosurgery		0	192	175
Urology	5,792	4,457	12,995	14,662
W&C: Gynaecology	3,935	3,998	17,589	19,129
Obstetrics / Maternity	6,792	6,746	11,620	12,096
Paediatrics	6,590	6,750	16,733	17,494
Psychotherapy		0	15	32
Diag: Chemical Pathology		0	567	639
Total	105,520	105,009	322,032	346,635

*Includes General Medicine, Renal Medicine (Nephrology), Diabetic Medicine, Endocrinology, Geriatric Medicine

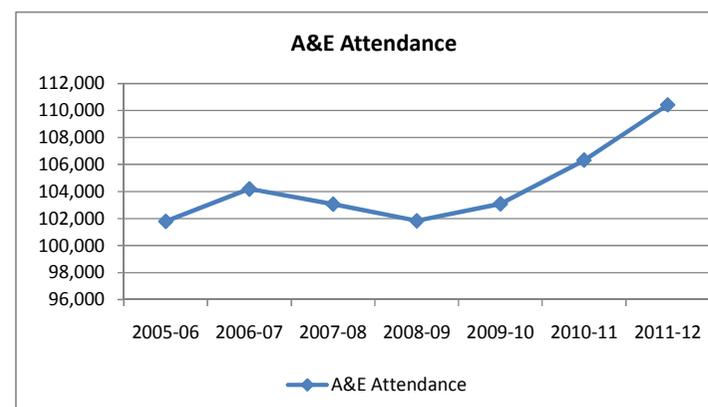
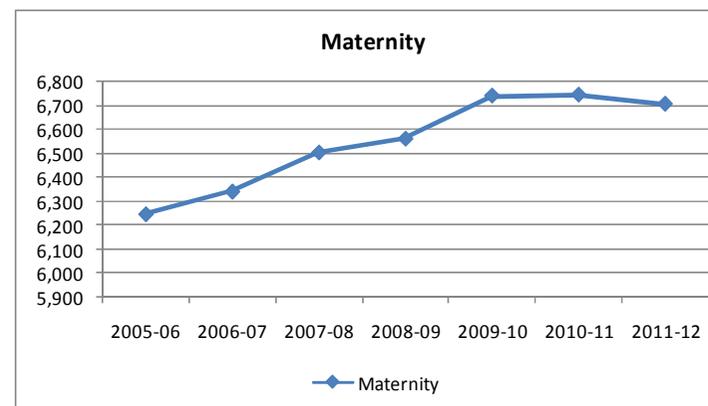
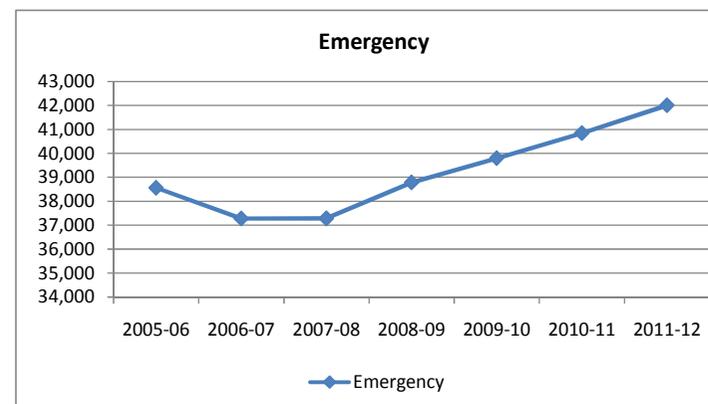
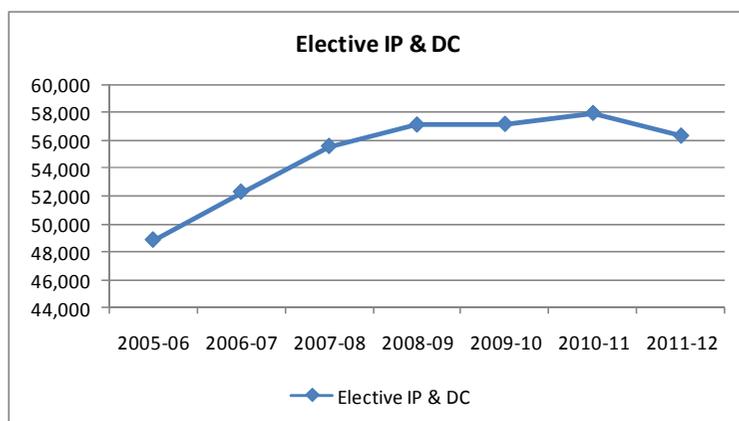
** Includes General Surgery, Vascular Surgery, Upper GI Surgery, Colorectal Surgery, Breast Surgery

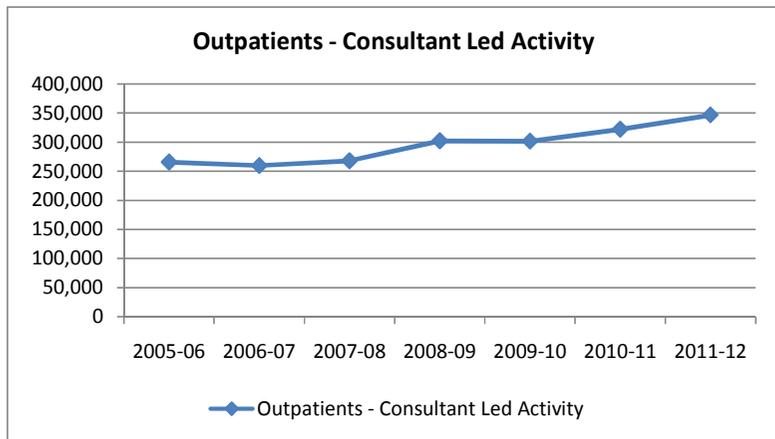
Table 2.2 Other Patient Activity by Specialty				
Specialty	Inpatient		Outpatient	
	2010/11	2011/12	2010/11	2011/12
ECC: Non Con / Non Chargeable			1	0
H&N: Non Con / Non Chargeable			5,774	7,073
Med: Non Con / Non Chargeable			52,039	55,530
MSK: Non Con / Non Chargeable			3,072	4,075
Onc: Non Con / Non Chargeable			21,706	23,957
Oph: Non Con / Non Chargeable			9,192	7,292
Surg: Non Con / Non Chargeable			8,785	10,069
Ther: Dietetics			4,431	5,956
Occupational Therapy			6,895	7,288
Physiotherapy			62,128	59,129
Speech and Language			5,475	6,110
W&C: Non Con / Non Chargeable	5,504	5,511	32,290	34,444
Midwife Episode			65,401	64,775

Includes Other Clinical Activity (split out from OP from Oct-11)

2.3 Activity

The graphs below show the trends in activity since 2005/06. Please note 2011/12 saw a significant movement of Daycase, Outpatient First and Outpatient Follow Up activity into the Outpatient Procedure activity type as per national rules.





Putting Patients First



Section 3: Commentary

- 3.1 Clinical Quality Improvements
- 3.2 Service Developments
- 3.3 Delivering the Financial Plan
- 3.4 Performance against Key Targets and Standards
- 3.5 Commissioner relations and contract delivery
- 3.6 Board Development
- 3.7 Progress with the Foundation Trust Application

3.1 Clinical Quality Improvements

Please see Section 7.

3.2 Clinical Service Developments

The key service developments within 2011/12 were:

3.2.1 Service Reconfiguration

During the year the Trust completed the outline business case for the Future Configuration of Hospital Services including the development of a new women's and children's centre at the Princess Royal Hospital. In April 2012 the Full Business Case was approved by the Trust, West Mercia PCT Cluster, Shropshire County Clinical Commissioning Group, Telford & Wrekin Clinical Commissioning Group and endorsed by the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin. The Full Business Case will be submitted to the Strategic Health Authority in May 2012 and, if supported, capital works will commence in 2012/13 for completion in 2014/15.

3.2.2 Unscheduled care

As part of the Trust's drive to improve patient flow through its unscheduled care service a number of service changes were introduced in 2011/12:

- An acute medical short stay facility at the Princess Royal hospital site within the medical assessment unit.
- Increase in the use of ambulatory emergency care pathways at both the RSH and PRH sites.
- Introduction of the Bed Bundle to act as an improvement approach to facilitate earlier transfers from MAUs and discharge from the hospital
- Case management and discharge planning - A rapid improvement program that supported better multidisciplinary working and timely discharge lead to the development of the integrated case management team to support wards where the post hospital needs of the patient are complex.
- Frail Elder project introduced the concept of a frail elder team to facilitate, where clinically appropriate, the discharge of patients within the first 72 hours of their hospital stay.

- The development and implementation of an electronic referral form to initiate a social care assessment, thereby reducing the time taken versus a paper system.

3.2.3 Trauma Unit designation

As part of the national drive to deliver best practice in trauma care and to meet commissioning intentions, the Trust submitted its bid for the RSH site to be its designated Trauma Unit and to work alongside University Hospitals North Staffordshire as one of three Trauma Centres across the West Midlands. This bid was accepted and from March the new network arrangements came into effect.

3.2.4 Orthopaedic pre-operative assessment

The Trust introduced in 2011/12 improved pre-assessment for Orthopaedic elective surgery to more effectively manage clinical risk of anaesthesia, optimise theatre and bed utilisation, and provide adequate and appropriate procedure and rehabilitation assessment to enable informed decision making and informed consent for the patient.

3.2.5 Capital Developments

- **Second Emergency Obstetric Theatre:** The Trust allocated £714,000 for the conversion of a labour room into second emergency obstetric theatre. By doing this reduced the risks associated with timely access to theatre for emergency obstetric cases.
- **Cancer and Haematology Centre Development:** Together with the Lingen Davies Cancer Fund who donated £3.2 million the Trust made substantial progress in 2011/12 on the completion of the new Cancer and Haematology centre at RSH at a cost of £4.8 million.
- **Replacement Linear Accelerator** The Trust approved the replacements of one of its two linear accelerators in 2012/13 at a cost of over £2.5m

3.2.6 Whole Trust change projects

- **Electronic request and results:** The Trust began work on the development of a comprehensive electronic request & results reporting system to deliver improved safety and timely in the request and management of diagnostic results.

- **Patient Nutrition:** In February 2012 the Trust introduced protected meal times for all patients as part of its programme to improve inpatient care. This initiative recognises the vital part that nutrition plays.
- **Non-medical e-rostering:** The roll-out of a non-medical e-rostering system began in 2011/12 to improve workforce management, focusing initially on ward areas.
- **Tele-health:** A trial of state of the art Video-conferencing equipment began in quarter 4 of 2011/12 to link up the Trust's two hospital sites for education and training events and for cross site meeting purposes. This development marks the start of phase one of the roll out of tele-health technology into clinical practice within the Trust.
- **Patient/hospital status at a glance:** In order to develop greater patient visibility at a ward and hospital level work began on the introduction of patient/hospital at a glance screens to be sited in each ward across the Trust. The project will deliver a system that is both linked to the Trust's patient administration and the VitalPac patient early warning system.
- **Comfort Rounds/intentional rounding:** Hourly/2 hourly comfort rounds were introduced midway through 2011/12 to ensure that patients were supported on a regular basis for hydration, pain management and toileting. This process has been evaluated well by patients.

3.3 Delivering the Financial Plan

The Trust's turnover in 2011/12 was £299.9m and we made a small financial surplus of £59k.

In making this surplus the Trust was faced with an underlying recurrent deficit of £14.4m at the start of the year and although significant cost savings plans were identified and delivered, the Trust received £6.5m financial support during the year. Through this programme of support and delivery the Trust ended the year in recurrent financial balance for the first time since it was established in 2003. This provides the financial foundations that will be needed for the delivery of sustainable high quality services in the current economic climate.

Expenditure

From our total budget:

- 66% (£200.1m) was spent on staff who provide health care (e.g. doctors, nurses, midwives, therapists, healthcare assistants, radiographers) or who provide essential support services (e.g. portering, catering, cleaning, technical and scientific staff, HR, payroll).
- 17% (£51.1m) was spent on drugs, dressings and other costs directly related to providing health care.
- 9% (£28.4m) was spent on essential supplies (e.g. uniforms, linen, food and transport), accommodation (e.g. electricity, gas, water, rates, furniture) and administrative & support services (e.g. postage, telephones, training).

The remainder (8%) covered other essential costs such as our contribution to the national Clinical Negligence Scheme for Trusts.

Income

The majority of our income 90% (£271.1m) was for clinical services, with the remainder 10% (£28.7m) for non-clinical services such as education. Nearly 92% of our clinical income came directly from our three main "commissioners" who purchased services from us on behalf of local patients and communities. These were:

- Shropshire Primary Care Trust (49% of our direct clinical income during 2011/12).
- Telford and Wrekin Primary Care Trust (35% of our direct clinical income during 2011/12).
- Powys Teaching Health Board / Bwrdd Iechyd Addysgu Powys (7% of our direct clinical income during 2011/12).

In addition to these direct contracts and service level agreements, these three organisations also commissioned certain specialist services (e.g. renal services, neonatal services) through regional consortium arrangements such as the West Midlands Specialised Commissioning Group and Health Commission Wales. Income from these regional specialised commissioning arrangements as well as "other clinical income" (such as private patients, overseas visitors and the NHS Injury Cost Recovery Scheme) accounted for the remaining 9% of income.

Financial Overview

The national priorities for the NHS were set out in the NHS Operating Framework 2011/12. For the fourth year, the national priorities continued to be:

- improving cleanliness and reducing healthcare associated infections
- improving access
- keeping adults and children well, improving their health and reducing health inequalities
- improving patient experience, staff satisfaction, and engagement; and
- preparing to respond in a state of emergency such as an outbreak of pandemic flu.

The Trust Board approved a financial plan to deliver a breakeven position with the year end position delivering a £59k surplus (including £6.5m of financial support). Over the period the Trust has faced the following impacts within its financial position:

- National Tariff increases in income of £4.2m
- Increased volumes and increased mix of complex cases in income of £23.2m
- Increased usage of high cost drugs in income of £3.4m
- Investment in the skill mix of staff together with additional costs associated with employing staff of £17m
- Full implementation of the European Working Time Directive of £2m
- Increase usage of temporary and agency staff at premium rates of £5m
- Increased costs of delivering activity via non pay costs of drugs and clinical supplies of £6.6m

In line with NHS requirements the Trust reports its accounts in compliance with the NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. For the year 2011/12 there has been 1 new accounting standard adopted by the Trust relating to the treatment of donated assets. As required by the adoption of this standard the prior year comparative figures have been restated within the annual accounts.

Financial Duties

The Trust achieved all of its statutory financial duties:

- To achieve a break even position on the Statement of Comprehensive Income. A surplus (before asset impairments and impact of donated assets) of £59k was recorded.
- To achieve a capital cost absorption rate of 3.5% The Trust achieved a rate of 3.5%.
- To meet the External Financing Limit which is the limit placed on net borrowing. The Trust's target of £1,029k was achieved with an actual external financing limit of £1,027k.
- To meet the Capital Resource Limit which is the limit placed on net capital expenditure. The Trust's target of £10,200k was achieved with an actual capital resource limit of £9,202k.

Capital Programme and the Trust Estate

The Board continued to invest in the development of the Trust's facilities. In 2011/12 the Trust invested £9.2million, including:

- £2,300k for a replacement linear accelerator within the cancer services centre.
- £1,800k relating to initial costs of the 'Keeping It In The County' reconfiguration of services project.
- £600k to complete the 'state of the art' off site decontamination facility.
- £450k to upgrade the Trust's telecommunications infrastructure.
- £300k for the 'year one' upgrade to the Trust's patient monitoring equipment.

3.4 Performance against Key Targets and Standards

The Trust's end of year performance against key national targets for 2011/12 is set out in the table opposite.

The assessments used in the table are in accordance with the Department of Health's Performance Assessment Framework.

The Trust has been unable to deliver and sustain performance against the A&E 4-hour 95% target during the year. Improving patient flow remains a key priority, with a number of workstreams being introduced in-year. The Trust is

working closely with its commissioners and health & social care partners in this regard.

Performance Indicator	Performing	Under-performing	2011/12 Outturn
Four-hour maximum wait in A&E from arrival to admission, transfer or discharge ¹	95%	94%	94.31%
MRSA	0	>15D*	1
C Diff	0	>15D	41
RTT - admitted - 95th percentile [®]	<=23	>27.7	42.10
RTT - non-admitted - 95th percentile [®]	<=18.3		28.15
RTT - incomplete - 95th percentile	<=28	>36	33.11
RTT - admitted - 90% in 18 weeks	90%	85%	68.59%
RTT - non-admitted - 95% in 18 weeks	95%	90%	87.31%
2 week GP referral to 1st outpatient	93%	88%	97.86%
2 week GP referral to 1st outpatient - breast symptoms	93%	88%	98.23%
31 day second or subsequent treatment - surgery	94%	89%	94.47%
31 day second or subsequent treatment - drug	98%	93%	98.83%
31 day diagnosis to treatment for all cancers	96%	91%	97.54%
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	94%	89%	98.78%
62 day referral to treatment from screening	90%	85%	93.52%
62 day referral to treatment from hospital specialist	85%	80%	92.55%
62 days urgent GP referral to treatment of all cancers	85%	80%	85.38%
Patients that have spent more than 90% of their stay in hospital on a stroke unit	80%	60%	87.80%

The Trust has not achieved its 18-week referral-to-treatment (RTT) targets for either admitted or non-admitted patients for 2011/12. The Trust began the year with a significant backlog of patients (i.e. patients already waiting over 18 weeks), rising to a figure in excess of 5000 patients at the end of May. This represented 25% of the total number of people waiting (open clocks), compared to a regional average of 6-7%. Through a combination of improved processes and additional non-recurring activity the backlog is now 5-6% and

the Trust expects to be delivering the overall RTT targets for admitted and non-admitted patients from April 2012 onwards.

The Trust achieved all its cancer targets for 2011/12. In-year, the area of greatest concern has been the overall 62-day target which was below target for each of the first 4 months of the year. However, performance has been above target for each subsequent month and the Trust achieved 'year-to-date' delivery in January and has sustained this.

The Strategic Health Authority introduced a revised Provider Management Regime in January 2012 (beginning with and reporting December performance). In shadow form until April 2012, the process includes the Trust formally signing off completed performance templates at Trust Board before submitting them on a monthly basis. The templates are discussed further in Section 8 and are included with the Integrated Performance Report to the Trust Board.

3.5 Commissioner relations and contract delivery

The Trust has worked closely with its two main English commissioners (Shropshire County PCT and NHS Telford & Wrekin) and Healthcare Commissioning Services (HCS) during the course of 2011/12. There have been regular performance and quality review meetings and issues that have arisen in-year have been discussed and progressed within an appropriately challenging and constructive 'what can we do to help' environment.

Both commissioners have been supportive across a range of issues during the year. With regard to 18-week RTT performance, for example, additional non-recurring support has been provided to help clear the backlog, the commissioners have worked with the Trust to place or redirect patients to alternate providers for 'challenged' specialties and both commissioners have contributed positively as members of the Trust's RTT Delivery group.

There have been a number of problematic issues to manage with regard to the Trust's third largest contract – that with Powys LHB (worth approximately 8% of the Trust's income). The most significant is a disagreement as to when and how the LHB's referral management process for routine referrals became operational. This a historical issue and there are no issues in relation to the current operation of the referral management process. Contract negotiations for the year ahead have focused on the LHB aspirations to implement a range of admission avoidance, pathway redesign and 'care closer to home' (i.e. in Powys and/or by Welsh providers) initiatives to reduce activity and therefore reduce contract spend at the Trust. The Trust is committed to working with the

LHB on such schemes, but with the recognition that the LHB must fund appropriately the activity that the Trust ultimately undertakes on its behalf.

3.6 Board Development

In order to progress the Trust's FT application, SaTH have implemented a Board Development programme that addresses the key components of a high-performing Board and will satisfy Monitor's requirements. The development plan covers Monitor's seven domains:-

- Board capability and capacity
- Understanding the business – Quality, Resilience & safety, Legally constituted, Good business strategy, Financially viable
- Sound governance – compliance with statutory requirements, service performance, local health economy issues

These are delivered as a full day programme, off-site.

The sessions have been divided into three main stages:

- Stage 1 - Board capability and capacity (June – October 2011)
- Stage 2 – Understanding the business (Oct 2011- March 2013)
- Stage 3 – Compliance requirements (March 2013 to authorisation)

STAGE 1 BOARD CAPABILITY AND CAPACITY (June 2011 – October 2011)

This work was led by Chantry Vellacott (CV) following a mini-tender process to identify the most appropriate supplier. The key elements are:

- Critical Review of Board Papers
- Board capacity & capability assessment
- Board workshop – Handling tough times ahead

Overview of Board capability and capacity programme

(i) Critical Review of Board Papers

This includes desktop review of Board papers, assessment and summary report and feedback with recommendations to the Trust.

(ii) Board Capability and Capacity Assessment

Using an approach of structured questionnaires and interviews with each Board Director, CV applied a proven Board development diagnostic framework, which in conjunction with Board observation and a high level review of key governance systems and processes provided an opinion upon the following dimensions:-

- Board skills and experience
- Organisational understanding of Board Directors
- Operation of the Board
- Overall Board capability

Each of the Directors completed a concise questionnaire covering the four dimensions and were individually interviewed. The findings were triangulated and a report produced which made recommendations for specific development action by NEDs, EDs and overall views.

(iii) FT Board Development Workshop and Action Plan

A session entitled 'FT Authorisation – Handling Tough Times Ahead', was held using downside mock Board papers and discussion as a role play exercise

The ensuing debate and actions agreed were analysed collectively using CV's experience of Monitor's expectations, and their observations and research on the Board and its governance arrangements /culture.

STAGE 2 UNDERSTANDING THE BUSINESS (Oct 2011- March 2013)

This work has been delivered largely by Trust staff. The programme covered the key elements of the Trust's strategy, business planning and governance framework. Each of the leads presented an overview of their area to the Board along with a short summary of the key issues. These form the basis of the Trust's Integrated Business Plan (IBP) and Long-Term Financial Model (LTFM). The key areas to cover are:

- Formulating Strategy
- Financial Governance
- Quality & Safety Strategy
- External Relationships
- Governance

STAGE 3 COMPLIANCE REQUIREMENTS (March 2013 to authorisation)

This is the final part of the process and will occur from March 2013 onwards as the final part of the trust's application process. Currently this section will focus on:-

- FT Board certification and statements
- FT Compliance Framework
- Final preparation for Monitor Board2Board

3.7 Progress with the Foundation Trust Application

The Trust is committed to improving the quality of acute services across Shropshire and Mid-Wales and views the application for and achievement of FT status as a key 'vehicle' to facilitate this end. In particular, becoming an FT will:

- Enable the Trust to be more explicitly and effectively accountable to its local communities via a robust and thriving membership.
- Give the Trust greater freedom to innovate and develop in a way suited to its populations and location.
- Ensure that the Trust maximises opportunities to provide integrated services for patients.
- Allow the Trust to create and retain planned financial surpluses, giving it more freedom to invest in and develop services that meet the needs of the community.
- Enable the Trust to focus on its efficiency and productivity, resulting in a better understanding of the Trust's 'business' and helping to ensure that resources are used more effectively.
- Allow us to develop a workforce strategy that is bold for the future, recognising outstanding contributions and success, and rewarding excellent performance appropriately.

There is a robust programme structure in place with SMART outputs. Thus far the Trust has achieved all the required milestones.

Putting Patients First



Section 4: Strategy and Service Developments

- 4.1 Strategic Context – the Local Health Economy
- 4.2 Commissioning Arrangements
- 4.3 Developing our Strategy and Long Term Organisational Objectives
- 4.4 Supporting Strategies
- 4.5 Key Service Developments

4.1 Strategic Context – the local health economy

Over 99% of our services are provided to patients from Shropshire, Telford & Wrekin and northern and eastern areas in Powys. Whilst most of Shropshire and Telford & Wrekin would see our hospitals as their main local acute hospital, our catchment within Wales only includes approximately half of the overall population in Powys.

Our catchment area, encompassing around half a million people, extends from the sparsely populated Powys in the west, through rural Shropshire to urban Telford. The main population centres are Shrewsbury and the new town of Telford. Alongside these major towns the area contains numerous smaller market towns including Bridgnorth, Ludlow, Market Drayton, Newport, Newtown, Oswestry, Welshpool, Wem and Whitchurch.

Within the local catchment area there are 3 distinct populations:-

Telford & Wrekin

- Telford & Wrekin is comparatively younger and less affluent than Shropshire, with 24% of its population living in deprivation quintile 1
- Telford & Wrekin is predominantly urban and has a higher proportion of residents from a Black & Minority Ethnic (BME) group, compared with Shropshire

Shropshire

- Shropshire is an ageing population with a large proportion of its residents living in a rural geography and comparatively fewer people living in deprivation than the national average
- The majority of the population are of white origin

Powys

- Powys, similarly to Shropshire, consists of an aging population with comparatively fewer people living in deprivation than the national average
- Powys has the highest proportion of residents living in a rural setting

The population in Shropshire and Powys is considerably older than the national average with 22% and 24% of the population over 65 respectively, compared with 17% nationally

The ageing demographic will increase demand for acute services over the next 5 years and beyond. As the proportion of over 65s is expected to grow by 2020, the increased prevalence of long-term conditions will put further pressure on services

As part of our externally commissioned market assessment exercise we assessed the epidemiological needs of our population. This assessment told us that within our local population there is a high prevalence of heart related conditions and diabetes, and high growth is predicted in dementia. Within Powys there is also a higher recorded incidence of cancer and COPD, however, this may be due to better screening and diagnosis in the area.

The local demographics and health needs projections have shaped the development of our future strategies.

4.2 Commissioning arrangements

Shropshire County PCT published its Strategic Plan for 2009-2014 in February 2010 detailing its vision to improve the health and wellbeing of people in Shropshire through partnership working to provide high quality and safe and responsive services in the most appropriate setting.

The strategy is based on 6 key themes:

- Tackling health inequalities
- Support for healthy lifestyle choices and managing long term conditions
- Promoting mental health and well being
- Developing care closer to home
- Developing vibrant community hospitals
- Developing modern health care

NHS Telford and Wrekin, in partnership with Telford and Wrekin Council, published its Health and Well Being Strategy, the objective being to improve the health and wellbeing of the population of Telford and Wrekin by:

- Reducing health inequalities
- Providing access to a range of quality services to meet health needs

- To ensure delivery of key national and local targets including financial balance
- To support the development of good quality providers of health services
- To engage with the whole community with regard to future services

NHS Wales published its 'Together for Health' strategy for 2011-16 detailing the need for service transformation, identifying 7 major areas for change as follows:

- Improving health as well as treating sickness
- One system for health – integrated NHS bodies
- Hospitals for the 21st century as part of a well designed fully integrated network of care
- Aiming at excellence everywhere
- Absolute transparency on performance
- A new partnership with the public
- Making every penny count

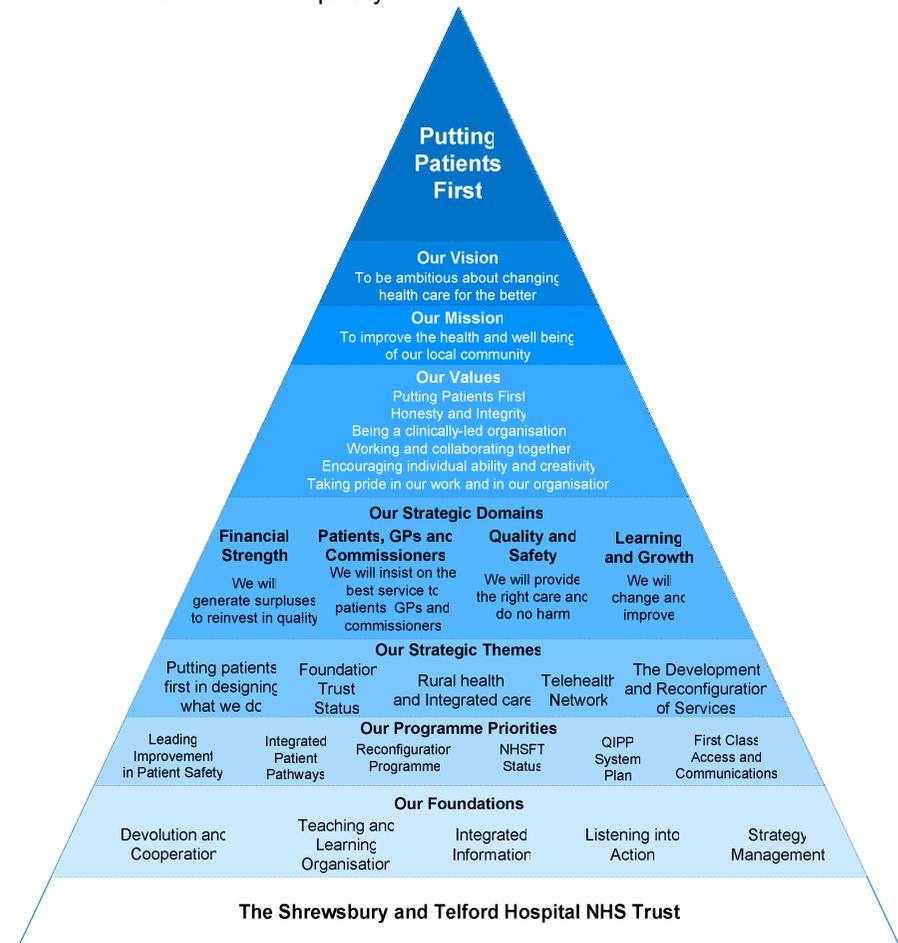
4.3 Developing our strategy and long term organisational objectives

Our strategy framework is detailed within our Management System (Our "Pyramid", opposite) which brings together our mission and vision and identifies the programmes that will enable us to deliver our organisational objectives. Our strategy has been developed within 4 domains (adapted from Kaplan and Norton): Quality and Safety; Patient, GP and Commissioner; Learning and Growth and Financial Strength.

Developing a strategy that is balanced between these four domains will ensure that we:

- Focus on what internal processes we must excel at if we are to improve the **quality and safety** of our care.
- Focus on what we have to do to meet the needs of **our patients, GPs and commissioners**.

- Focus on the **learning and growth** that will prepare us for the future through developing our staff, the technology we use and the innovation we create.
- Focus on what it will take to create the **financial strength** to enable us to invest in the quality of our service



'Putting Patients First' is central organisation principle and at the heart of all of our strategic intentions.

Our organisational objectives have been developed through a process of stakeholder needs analysis and an understanding of the gap of where we are and where we want to be.

To communicate our strategy within the organisation we have produced a Strategy Map, a “plan on a page”, which represents the most important elements of our strategy. This plan on a page will help everyone to understand what we must do to deliver our strategy and achieve our vision of the future.

Our “plan on a page” for 2012/13 is included at Appendix A. We have defined our objectives to provide continuity and direction for the Trust moving forward.

4.4 Strategic themes

The key themes that run through our strategy are:

- Putting Patients First – designing what we do for our patients
- A Foundation Trust – a clear purpose
- Rural Health and Integrated Care – an expert role
- Telehealth Network – systems to deliver care locally
- The Development and Reconfiguration of Services – developing safe, high quality and sustainable services

4.4.1 Putting Patients First

Putting Patients First makes us think what really matters. It is about putting the patient at the very centre of our work and focusing on the outcomes of the care that we deliver. It is also about supporting clinical leadership throughout the whole organisation so that people who are closest to the patient are able to make decisions in the best interests of the patient.

Our business is primarily driven by the outcomes we want to achieve for our patients. *Putting Patients First* means giving the best patient experience we can, doing so safely and using the evidence of what works best to inform our practice. This theme underpins our whole strategy and service development plan.

4.4.2 Foundation Trust Status

The organisational rigour that *becoming an FT* demands is something we aspire to and which will allow us to make the right decisions and secure the widest possible range of specialist care for the people that we serve.

Whilst we are ambitious to develop the quality, range and reach of local services, we also recognise we need to demonstrate our financial health.

Our strategy therefore is about building a solid foundation which can be used as a platform for future growth. We seek operational efficiencies to ensure ongoing financial viability, meeting and exceeding quality and performance targets and ensuring future clinical viability of what we believe are our core services.

4.4.3 Rural Health and Integrated care

We must promote the sustainable use of resources across the health economy and will therefore offer leadership to the development of an *integrated healthcare system*. We expect this will help to improve the quality of service our partners and we can provide.

This model of delivering care should improve resilience and reliability of our services and at the same time control and lower the cost of provision. We therefore aim to act as a “service integrator” and establish a series of integrated pathways of care for our population. The evidence base for this approach has been tested in developing our plans.

Our future assumptions will incorporate reducing reliance on institutional care, less reliance on acute care and one that supports and sustains people in their own homes. The Trust is therefore developing its plans through 6 service areas or pathways that are likely to form the basis of any radical re-working of a health care system:

- End of Life Care
- Long term Conditions Management
- Frailty and Older Person Care
- Dementia Care
- Hospital at Home
- Front ended Acute Service

4.4.4 Telemedicine

We believe, through telemedicine, that there is huge scope to improve local access to care for patients at local level, make care more consistent and reliable, improve access to expert decision makers, and improve patient flow and lower costs for organisations including ourselves.

We envisage a system that following a careful analysis of risks and benefits would progressively offer patients, and their carers to benefit from these services. We will develop the partnerships we need to build this capability.

We have agreed that the Ontario Telehealth Network (the world's largest T Health provider) will work as a learning partner in support of developing this strategy.

4.4.5 Reconfiguration of services

The reconfiguration principles set out by commissioners NHST&W and SCPCT at the beginning of the reconfiguration programme were:

- Keeping two vibrant, well balanced, successful hospitals in the county
- A commitment to having an Accident and Emergency Department on both sites
- Access to acute surgery from both sites

These principles were underpinned by two essential requirements; making services safer now and in the future and making services sustainable now and in the future and were considered in the context of a wide range of current and future issues and challenges.

The reconfiguration of acute surgery and women and children's services are one of our key service developments identified within our Integrated Business Plan.

4.5 Key service developments

The key drivers for our service development plan are articulated within our IBP (Chapter 3; Strategy) and (Chapter 4: Market Assessment). There are a number of desired outcomes that have shaped our service development plans, these include:

- Improving the income and expenditure balance of our services
- Delivering services in a rural setting by seeking the means through which, where practical, service integration can be achieved.
- Developing services that deliver growth for the Trust but in a cost neutral manner for commissioners through repatriation of patient flows to improve the service choice for the population.

- Reconfiguration of services to ensure that they are clinically safe and sustainable in the future

4.5.1 The reconfiguration of acute surgery and women and children's services

During 2010 we developed and consulted on a strategy called '**Keeping it in the County**'. This was a proposal to re-shape services that faced particular safety or sustainability challenges. The services affected include:

- Inpatient paediatrics
- Consultant obstetric and midwife led maternity care
- Acute surgery (upper and lower gastrointestinal surgery and vascular surgery)
- Head and Neck surgery (ENT and maxillofacial surgery) and urology.

Following extensive consultation we have secured approval of an outline business case to re-shape these services. This includes the development of a women and children centre at Princess Royal Hospital and an acute surgical and trauma unit at the Royal Shrewsbury Hospital.

Developing the options and the appraisal process for reconfiguring surgery and women and children's services has been a clinically led process. The total capital cost of this reconfiguration programme which is a mix of new build and refurbishment, is £35million. The majority of this is for the new build element at PRH (£28m). Details of the economic analysis and affordability can be found in full in the FBC.

4.5.2 Development of cancer services

Our Radiotherapy Department requires two Linear Accelerators in order to meet current demand. Funding for a replacement of one of the Linear Accelerators has been approved and will be funded through the Trust's capital programme. The equipment was purchased in 2011/12 and enabling work will be allocated from the 2012/13 programme.

This development will provide additional capacity and an enhanced level of service enabling us to compete with neighbouring Cancer Centres and enabling us to provide high quality services locally for our patients hence reducing the need to travel for healthcare.

Our capital plans for the new cancer build will provide high quality services in a state of the art building. Work has already commenced on the new Cancer Centre and is expected to be completed by autumn 2012.

4.5.3 Development of cardiology services

The Trust wishes to develop a local non primary PCI service and devices service to offer improved access to the population of Shropshire, Telford and Wrekin and Mid Wales; it builds on an existing strength to ensure service sustainability and service capacity into the future

Historically interventional cardiology has been regarded as complex and difficult to deliver outside of tertiary centres. In recent years this has changed with a shift towards the development of services closer to the patient.

The Trust employs three consultant cardiologists with the required skills to support the introduction of a non primary PCI service locally. The Trust has already invested approximately £2.5 million improve the catheter lab and equipment to provide modern facilities and the required technology to develop the services outlined.

4.5.4 Repatriation of market share

Our Service development plans will include an active marketing strategy to repatriate existing services back into the county and also to increase our market share in neighbouring counties.

The Trust intends to utilise a number of strategic initiatives including, GP engagement strategy and an account management approach to maintain and improve relationships with local GPs and to develop new relationships with GPs out of the county.

4.5.5 Expansion of private practice

We are looking to explore the private patient market as an enabler of profitable growth, which will then be reinvested back into NHS services. Alongside the upside revenue potential, there are a number of advantages associated with increasing private patient care, including:

- Optimising the use of NHS facilities and maximising operating efficiencies within the Trust
- Facilitating easier and more convenient consultant visits between NHS and private patients

The Trust is presently developing a strategy to increase the level of income generated in respect of private patients. The level of income is expected to remain constant during the next two years at levels consistent with those generated in 2011/12. In 2014/15 income is planned to grow by approximately £0.9m and by a further £0.5m in the 2015/16 year.

Putting Patients First



Section 5: Alignment to Commissioner Plans

- 5.1 Shropshire County PCT and NHS Telford & Wrekin
- 5.2 Local QIPP Schemes
- 5.3 Powys LHB
- 5.4 Specialised Commissioning
- 5.5 Other Commissioners

5.1 Shropshire County PCT and NHS Telford & Wrekin

Contract discussions have taken place jointly with our 2 local commissioners to ensure, as far as possible, a consistent approach to negotiations for 2012/13. Contract offers have been made and accepted and detailed activity and finance schedules, together with the general contract documentation, will be completed as per national requirements and timescales.

Activity baselines have been set based on an agreed view of 2011/12 forecast outturn, less non-recurring activity associated with reducing the Trust's 18-week backlog (see section 3.5).

A review of actual outturn will be undertaken once the final position is known to determine whether there is any risk associated with the contracted activity levels.

Further reductions to the baseline activity have been made to allow for the transfer of commissioning responsibility for some services to Specialised Commissioning (e.g. radiotherapy) – this will be neutral in overall contracting terms – and in relation to the health economy-wide QIPP initiatives (see 5.2). The commissioners have not allowed for any activity growth for demographic changes within the contracted activity levels.

During the course of 2011/12 the Trust identified and raised a series of 'coding and counting' issues that it requested funding for in subsequent years. Agreement has been reached on a number of these, equating to approximately £4million of additional funding for 2012/13 (approximately £1.5million of this represents the final transition year of issues raised and agreed in previous years, eg the tariff for community midwifery contacts). As part of the agreement to fund these, the commissioners have indicated that they wish to undertake a number of service reviews in-year to better understand, and if appropriate change, the associated patient pathways. The Trust is fully committed to working with the commissioners in these reviews.

5.2 Local QIPP Schemes

The reduction in planned activity reflected in the contract numbers, due to the delivery of QIPP initiatives during 2012/13, equates to approximately £5.3million (£8.8million on a full-year basis) across both commissioners. The Trust is committed to playing its part, working alongside commissioners and its other health and social care partners, to ensure delivery on these initiatives and is involved in clinically-led discussions with commissioners in how to take these forward (see below). The basis of the contract agreement however, is that any 'overperformance' due either to delays in implementation of a

scheme or the impact of a scheme on activity being less than anticipated, will be charged for.

For unscheduled care the Trust plays an active role within the local Urgent Care Network. There are a range of schemes either being discussed or already agreed that are designed to redirect admissions to alternative community-based services, shift activity away from admissions to ambulatory care and reduce the length of stay for patients that do need to be admitted. Examples include changes to working practices, based on an ambulatory care model, being introduced alongside (acute) physician-led Acute Medical Units and a 'frail and vulnerable patient' team has been established to focus on improving and streamlining clinical pathways for this specific cohort of patients.

For planned care, the commissioners have enhanced their 'procedures of low clinical value' policy and, following clinical engagement, the Trust has agreed to the proposed changes. A number of pilots agreed with commissioners and initiated during 2011/12 to replace consultant outpatient appointments with either telephone contacts (eg endocrinology) or 'straight to test' (eg cardiology) are being rolled out in 2012/13.

A 'consultant-to-consultant' referral policy has been agreed and is in place. The Trust has agreed to work with commissioners to better understand the cohort of patient activity that is discharged after the first outpatient appointment (quite high in some specialties) to see if alternative pathways may be more appropriate and during February the Trust hosted a workshop for consultants and GPs to discuss ways of making better use of Choose & Book, with particular emphasis on the use of Advice and Guidance to reduce the need for outpatient attendances.

5.3 Powys LHB

As highlighted in section 3.5, financial challenges mean that the LHB is seeking ways to reduce the level of demand it places on the Trust. The LHB does, however, recognise that it needs to fund activity that is either admitted to, or seen, at the Trust at national tariff where applicable or at the same locally agreed tariff as our main commissioners where national tariff does not apply.

At the time of writing this Plan there is no formal contract agreement in place with the LHB for 2012/13. Proposals to-date from the Trust have centred around a contract value based broadly on outturn activity (plus coding and coding issues as described in section 5.1) but with an agreed form of wording

that confirms the Trust's willingness to work with the LHB on admission avoidance and pathway redesign. The LHB has not discounted this but its stated intention would be to underperform on such a contract and the Trust will need to assess the level of risk associated with this. If agreement is not reached by the end of April then this will be escalated through the appropriate processes to reach a resolution.

5.4 Specialised Commissioning

Activity to the value of approximately £4.5million has been transferred from our local commissioners to Specialised Commissioning as part of the change in commissioning responsibilities, bringing the total contract value to approximately £14million. This contract has been agreed.

The main service elements of this contract are renal dialysis and neonatal care. The largest element that has now transferred relates to radiotherapy.

5.5 Other Commissioners

The Trust has a number of contracts with other commissioners (eg Welsh specialised Services). In total these represent approximately 2-3% of the Trust's total contract income. Contracts have been agreed that are broadly consistent with forecast outturn activity levels.

Putting Patients First



Section 6: Key Risks

- 6.1 Background
- 6.2 Risk structure
- 6.3 Training and education
- 6.4 Key risks
- 6.5 FT risks

6.1 Background

The Shrewsbury and Telford Hospital NHS Trust is committed to changing healthcare for the better and believes that our role as individuals, and as an organisation, is to provide the safest possible care at the highest level of quality we can afford using the best evidence of what provides the greatest benefit to patients.

The Trust Board recognises that to achieve this highest level of quality, it is essential that effective risk management should be part of the Trust's culture and strategic direction.

The Board is committed to an open and honest approach in all matters. It expects all staff to acknowledge that risks within the Trust can be identified and managed if everyone adopts an attitude of openness and honesty. The overall approach expected within the organisation is one of help and support rather than blame and recrimination.

The effective management of risk is central to providing the safest possible care at the highest level of quality we can afford whilst allowing the Trust to make the most of opportunities, and minimising the risks taken. Boards need to be able to demonstrate that they have been informed about all risks not just financial and that they arrived at their conclusions on the totality of risk based on all the evidence presented to them.

The purpose of the Risk Management Strategy is to detail the Trust's framework for setting objectives, providing assurance and managing risk to enable:

- The Trust to maintain a corporate risk register, that details those risks that could prevent the achievement of Trust strategic and operational objectives as stated within the Trust's business plan.
- The resulting risk register to be reported through the Trust Risk Management Executive to the Trust Board. The Risk Management Executive is the overarching risk management committee in the Trust.
- The Trust to develop an Assurance Framework that informs the Board of the effectiveness of key controls that seek to mitigate or manage principal identified risks to the Trust's stated objectives.
- The resulting Assurance Framework to be scrutinised by the Audit Committee.

The Trust aims to manage risk in an integrated way; considering all aspects of risk including clinical, non-clinical, financial, operational, business and strategic with the aim of minimising its exposure to risk.

The maternity service has a complementary approved risk management strategy which describes the processes in place in the Women's and Children's Centre for managing risk in this high risk environment as required by the CNST standards published by the NHSLA.

6.2 Risk structure

The Trust will maintain its structured approach to risk management. It is not possible to manage risks until they have been identified. Risk identification is the process of identifying what can happen or has happened and why. The first step is to review business plan objectives, identifying the Principle Risks (Hazards) that may impact upon the ability of the Trust or Centre to achieve its objectives. The Trust has produced a document 'Guide for ongoing Risk Assessment' to assist line managers.

The approach to risk identification includes:

- A "pro-active approach" to the identification and management of Principle Risks that may threaten the achievement of Strategic and operational objectives as identified within the Trust Business Plan.
- A "reactive approach" to the identification and management of risks that may threaten the achievement of the Trust Risk Management workstreams as indicated in Section 13.0 of this strategy.

6.3 Training and education

Training and education are key elements in establishing and maintaining the "risk management culture". They provide staff with the necessary knowledge and skills to work safely and to minimise risks at all levels.

The Trust will undertake to provide training in all areas for staff and other agencies working within Trust sites to ensure the development of a risk management culture.

This process will start at induction. All staff are required to attend a corporate induction programme on joining the Trust and this will include an introduction to the risk management culture within the Trust. The session will also encourage staff to self-assess their personal responsibilities and development needs in relation to risk management and the task they will be undertaking.

Action will be taken to ensure that accurate and consistent training records are maintained and that appropriate follow-up action is taken when staff do not attend mandatory or statutory training courses.

All Trust staff are required to attend certain mandatory risk management training courses. In addition certain staff groups are required to attend additional courses or undertake e-learning / distance learning programmes as appropriate, which are mandatory for their specific work groups, these are detailed in the relevant policies.

Staff health, safety and welfare programmes will be developed across the Trust. Specific consideration will be given to statutory requirements, violence in the workplace initiatives and stress reduction.

Each and every employee will have personal objectives linked to the corporate objectives, including training reviewed annually at time of staff appraisal in line with Trust policy. Where appropriate personal objective and development plans will directly link to identified risks.

Board members, Executive and Non-Executive Directors and other identified Senior Managers will be appropriately trained and skilled in risk management for their role as Board member or members of the Senior Management Team. They will be provided with bespoke Risk Awareness Training for Senior Managers to ensure that they have a clear understanding of their role and responsibilities for risk management throughout the organisation. Attendance will be recorded and forwarded to the Chief Compliance Officer. This will be reported in the Risk Management Annual Report to the Risk Management Executive.

6.4 Key risks

A key priority for the beginning of 2012/13 has been the development of a revised Board Assurance Framework, which is due to be finalised in May. The current draft is included overleaf and will be updated to reflect the decisions of the Board.

Table 2 – Summary action plan

Principal Risk	Sub risks (Corporate Risk Register number)	Lead Director	Oversight Committee
Principal Objective A: Financial Strength: We will develop & deliver robust plans that generate surpluses to invest in quality			
1 Failure to deliver financial surplus resulting in trust not being a viable service provider (CO:A)	Inability to deliver CIP programme (CRR 19)	COO	F&P
	Income loss from QIPP programmes understated (CRR 557)	FD	F&P
	Failure to deliver sustainable balanced I&E and cash surplus (CRR 18)	FD	F&P
	Failure to generate commercial income (CRR 558)	DBE	F&P
Principal Objective B: Patients, GPs and Commissioners: We will insist that we deliver the best service to our patients, GPs and Commissioners			
2. Unable to adapt to innovate and integrate patient pathways across health economy (CO: B)	Loss of patients to our competitors (CRR 559)	DBE	F&P
	Lack of agreed Health Economy System Plan (CRR 413)	CEO	TB
	Failure to grasp opportunities for greater integration between secondary and primary care (CRR 560)	CEO	TB
Principal Objective C: Quality and Safety : We will always provide the right care for our patients and ensure that they suffer no harm			
3. Unable to sustain improvement in delivery and culture of caring (CO: C)	Failure to sustain and improve patient experience & safe systems resulting in loss of confidence by regulators, commissioners & patients (CRR 415)	DQS	Q&S
	Failure to balance efficiency in use of beds with quality of patient care & effectiveness of outcomes (CRR 561)	MD	Q&S
	Failure to deliver benefits of reconfiguration in terms of a) capital & b) service outcomes (CRR 412)	DoT	a) F&P b) Q&S
4. Failure to achieve and deliver national and local targets (CO:C)	Unable to sustain delivery of national standards for access for a) quality & b) performance (CRR 11)	DQS COO	a) Q&S b) F&P
	Failure to meet goals and timescales of the transformation programme (Access) (CRR 562)	DoT	F&P
Principal Objective D: Learning and Growth: We will develop our internal processes to sustain our ability to change and improve			
5. Failure to ensure management and staff capacity and capability to deliver organisational strategy (CO:D)	Unable to improve morale and confidence of SaTH staff such that they justifiably say there is nowhere better to be a patient (CRR 423)	WD	Q&S
	Lack of capacity and capability amongst individuals and teams (CRR 416)	COO	F&P
	Failure to provide adequate information set for managers to deliver agenda – finance – budget /CIP, performance (CRR 418)	FD	F&P

6.5 NHS Foundation Trust

The government has set the expectation that all NHS Trusts will become NHS Foundation Trusts by 2014, and the Health and Social Care Act 2012 provides that NHS will not be able to exist in future. Given the vital importance of FT status to the safety and sustainability of local health services the principal current risks to NHS Foundation Trust authorisation are set out below. These are managed through the NHS Foundation Trust Programme Board

Risk description	Mitigating action taken	Likelihood x Consequence	Residual score	Status
Failure to deliver improved financial position – including working capital and CIPs	SLR introduced aligned to new Centre structure with monitoring of performance. CIP plans identified to deliver savings to achieve operating surpluses. Dedicated Programme Management Office established to track performance of CIP delivery.	3x5	 15	OPEN
Failure to deliver service performance improvements	Full Improvement plan agreed with commissioners and monitored by Board and PMO. Performance management arrangements in place with escalation procedure	3x5	 15	OPEN
Capacity to manage the impact of consolidation of financial management and operational performance whilst starting the FT pipeline	Project approach with robust measurable programmes in place and creation of Programme Management Office to ensure deadlines are delivered. Management and clinical restructure completed. Additional senior staff in post.	3x5	 15	OPEN

Putting Patients First



Section 7: Improving Quality and Safety



7.1 Background

During 2011/12 the Trust Board has focused both on improving quality and on improving the way we measure quality so that we have clear benchmarks in place for agreeing our priorities and targets for the future. With the implementation of Devolution and Cooperation during the year, there is strengthened clinical leadership in place across the Trust. With eleven Clinical Centres led by their Centre Chiefs the Trust Board therefore has greater confidence in systems for monitoring quality and leading quality improvements. This supports our central organising principle of Putting Patients First.

In last year's Annual Report we described our intention to develop a Quality Improvement Strategy. This was developed during the year with involvement of patients and frontline staff, and was approved by the Board in March. This strategy describes our priorities for improvement in patient safety, patient experience and patient outcomes. It also ensures that these improvements measurable so that we can track progress.

The Trust is clearly committed to continuous Quality Improvement and has worked with staff and patients to outline the areas for Quality Improvement for 2012 and beyond. Through our strategy, the Board and clinical leaders across the Trust will be supported to promote innovative ways to improve clinical outcomes whilst focusing on promoting and maintaining health and well being. One example of our commitment has been the "Leading Improvement in Patient Safety" (LIPS) programme commissioned by the Trust Board in 2011. During 2011 over 100 members of staff were involved in a major learning and improvement initiative as part of LIPS, and this has been re-commissioned with a second cohort taking place early in 2012/13. LIPS will continue to be one of our main vehicles for quality improvement going forward.

We have continued to work closely with our commissioning and GP colleagues in the last year to refine clinical pathways. One important example of this was the "Keeping it in the County" that ended in 2010/11 and has continued through 2011/12 through our Future Configuration of Hospital Services programme. Central to this work has been a robust process of quality impact assessment, drawing on the feedback we have received from patients, staff and partner organisations. Working with Clinical Commissioning Groups and the wider local health and care community will be core to ensuring care is delivered in the best interests of the patients, whether that is in their home or within the specialist clinical centre within the hospital. In essence providing the right care in the right place and by the right professional will be key to our success.

Our performance against measures of quality has been monitored closely by the Board, supported by detailed scrutiny by the Quality and Safety Committee, which is a formal committee of the Trust Board. With the establishment of the new Clinical Centres in October 2011, Centre Chiefs working with their wider clinical teams now have a central role in monitoring quality improvement and accounting for progress. The Trust has worked with clinical staff to establish key performance indicators to monitor Quality from the ward to the Board. This provides a basis for collective ownership and a continuous improvement drive.

The Quality Improvement Strategy provides a five year framework from which the Trust can be held to account for the annual improvements it aspires to deliver. The annual improvement outcomes from this Strategy will be published through the Quality Account each year. The Strategy document itself will need to be an evolving and iterative document being influenced by national policy and local requirements, however at the heart of our strategy are the improvements that staff and patients feel passionate. As a Trust we have both the obligation and the desire to focus on what matters most to our patients and our staff with the finite resources available to us. Quality improvement must go hand in hand with financial improvement so that we can secure the necessary resources to invest in future success. Our Quality Impact Assessment process, which we have refined and developed, will be central to this as it makes sure that the quality impact of our plans for the future is assessed and benefits are delivered.

An open and honest assessment of our progress and challenges to improve quality during 2011/12, and our priorities for quality improvement in 2012/13, can be found in the Quality Account which will be published by the end of June 2012.

7.2 Bringing Clarity to Quality

Our quality improvement strategy (QIS) is supported by explicit year on year objectives across the three domains of patient experience, patient safety and clinical effectiveness. It supports us to ensure that "quality is everyone's business" in our Trust. We also know that being open with the public we serve is essential if we are to build the confidence in our services. As an illustration of our ambition and of the public facing nature of the challenge we have agreed a goal of reducing the level of in-hospital mortality over the 5 year QIS by 25% (from the 2011 baseline). We believe this safety goal is a powerful and simple statement of intent. During 2010 and 2011 our HSMR was been higher than the national average. HSMR and overall mortality are now both declining. We began to implement the first stage of our strategy during

2011/12 and in that year we have seen a reduction of over 9% in crude death rates and we expect to see a continuing fall in both these measure over the lifetime of the Strategy and of the Integrated Business Plan.

We are seeing reductions in the number of falls and pressure ulcers but our ambitions will be to eradicate grade 4 pressure ulcers in 2012 and grade 3 pressure ulcers in 2013, with year on year reductions in falls. We have achieved England's best five-year mortality for colorectal cancer surgery and have a reputation for delivering the most patient friendly maternity service in the West Midlands, with the lowest intervention rates and a highly distributed service model.

Continuing to use national guidelines and best practice tools, we will develop and enhance the care delivery at the Shrewsbury and Telford NHS Hospital Trust and we will monitor not only the clinical outcomes but a range of patient experience feedback methods developed as a framework of best practice in caring for patients. Patients and staff have identified clear priorities for inclusion within this Strategy and we will continue to work with them to ensure that the annual quality Improvement plan and Quality Accounts produced each year support us to become a leading national Trust on quality patient care with optimum outcomes.

The LIPS (Leading Improvements in Patient Safety) Programme which we run in partnership with the National Institute for Innovation and Improvement is a key part of this quality improvement strategy. We have developed with our partner the first Trust level LIPS implementation with more than 100 key clinical staff participating in our groundbreaking launch in 2011. We expect that a further 500 of our key front line staff will have been trained in safety management over the next four years.

We believe that by working together we can redefine the reputation we have for the provision of excellent, safe and high quality health care. We will define our brand in these terms and monitor and measure its validity and strength.

Ensuring that Quality Drives our Agenda

We have through a number of discussions across the Trust and with partners outlined that we want to provide service delivery which is patient focused, with patients at the centre of everything we do. In essence, care delivered in the right place at the right time by the right individuals. We will deliver care in a variety of settings with our partners, most notably primary care practitioners.

We are clear however, that Quality drives our agenda and in doing so have asked the following question:

“What would it take for all patients to make very positive comments about our hospital and recommend us to their friends and family?”

7.3 How will we improve and how much by

We predict that through the development and implementation of the Quality Improvement Strategy, and by identifying ambitious annual Clinical Centre Quality Development Plans, we will achieve further improvements in clinical quality and patient safety over the next five years. This Strategy does not however, stand alone and fits with the Trust's overarching integrated business plan. The Integrated Business Plan will be supported by the following Strategies.

- Quality Improvement Strategy
- Workforce Strategy
- Organisational Development Strategy
- Information and technology Strategy
- Estates Strategy
- Risk Management Strategy

The Trust is confident that the five year Quality Improvement Strategy will deliver the following high level improvement and performance goals by 2017.

Achieving high levels of patient safety by 2017 evidenced by a reduced in patient mortality rate and demonstrated by 25% reduction in crude death rate from baseline in June 2011.

Underpinned and supported by:

- Elimination of “avoidable” hospital acquired pressure ulcers at grade 3&4 by 2013
- 80% reduction of inpatient falls resulting in harm by 2017
- Hospital acquired infections reduced year on year across 4 mandatory reporting criterion
- 100% compliance of WHO safer surgery checklists (2012/13) and 100% compliance on procedural check lists (2013)
- 100% compliance to required medication systems and processes with outcomes in NRLS reporting in top 10% performance nationally.

- 95% reliable standardised care in high risk and volume conditions and clinical process

Achieving ongoing improvements in patient experience with the aim of getting it 'right first time, every time' for all outpatients and inpatients.

Underpinned and supported by:

- Real time patient feedback being in top 80% performance with clear actions demonstrated on the 20% where experience is not optimal & to make those improvements whilst patients are still in our care.
- Excellent environment ratings PEAT (Patient environment action teams) inspections in all hospital wards and departments
- 95% of patients recommending our hospital to family or friends
- 90% of Outpatients rate their care as 'excellent' overall
- 95% of Inpatients rate their care as "excellent" overall
- Patient and Carer information leaflets provided for 100% planned procedures
- 100% Inpatient and Outpatient care delivery will be able to demonstrate carer and patient involvement in decisions and care delivery.

Being able to demonstrate clinically effectiveness through improved patient outcomes by 2017.

Underpinned and supported by:-

- Achieve comparable national best practice clinical outcomes consistently across all services
- Ensure 100% of all patients achieve their required constitutional rights on national waiting and access times

Improve effectiveness for patients requiring unscheduled care by:-

- Increase the number of elderly frail patients who can be effectively supported and discharged within 72 hrs to 80%.
- Reduce emergency surgical admissions by 5%.
- In A&E, being reviewed by a specialist within 1 hr of request and
- If decision to admit then admission to a bed within 4hrs

- Increase % day case rates on elective basket of procedures to 80% by 2016.
- Reduction in Staff sickness to 3.5%
- Annual delivery of the Trusts CIP and LTFM

7.5 The Board & Centre Clinical teams being sufficiently aware of potential risks to Quality

Over the last year, the Trust Board have recognised those areas where improvement is needed in clinical and operational performance. Through increased visibility of quality measures, the renewed focus through a Directory of Quality and Safety on the Trust Board, and supportive programmes such as LIPS and Listening Into Action the Trust is actively developing and maintaining a culture for quality improvement from the ward to the Board

This increased awareness of Quality and Safety is demonstrated through the development of a balanced score card approach from the ward and departments to the Trust Board, raising expectations of clinical managers and leaders - for example, shifting the mindset of all staff from falls and pressure ulcers being inevitable to being unacceptable to being eliminated.

Our heightened approach to quality and safety is improving awareness and reporting. This helped us to highlight 6 "Never Events" in 2011/12. Whilst every such event is regrettable and should not occur, effective reporting and learning ensures that improvements are made and sustained.

Overall, there has been a significant increase in reporting of serious incidents (195%). The positive reporting culture in the Trust is felt to have made a significant contribution to this.

The joint working between the Executive team and Centre Chiefs through core committees (Hospital Executive Committee and Risk Management Executive) has enabled a oversight and scrutiny of emerging risks. At all levels within the organisation there is a recognition that we want to build on this work to ensure that our performance monitoring of care provision is robust to ensure consistently safe and effective care.

7.6 Maintaining and measuring national minimum quality standards

While the primary focus of the QIS is a five year improvement agenda to identify, develop and deliver best practice and innovation, it is equally

important that the Trust achieves and maintains excellent performance against minimum national standards such as Care Quality Commission (CQC) essential standards, and national performance targets.

The Trust has achieved Level 2 CNST accreditation in 2012 in Maternity standards and Level 1 for NHSLA Risk Management Standards. Patient sensitive Indicators are monitored closely through a ward to Board process "Test Your Care" with a complementary process called the Health Assure system introduced into the Trust in late 2011 which provides an ability to demonstrate compliance with CQC standards, involving clinical teams. The Trust is working closely with CQC relating to recommendations from reviews during the year including a moderate concern issued in relation to standards of care at the Princess Royal Hospital. A follow-up review by the CQC took place in May 2012, which provided an opportunity for the Trust to demonstrate that recommendations from the previous visit had been addressed and that care provided by the Trust meets essential standards.

7.7 Building on our current Quality performance

We will focus on addressing the known issues that are a cause of concern for our patients as part of our commitment to continuous improvements in Quality as follows:-

- Getting it right first time/ first contact in patient pathways.
- Consistent and effective Communication- Care and compassion
- Providing information at each stage of the pathway
- Consistent clinical standards and practice- safe care
- Strong performance management of care that falls below the required standard
- Way finding (sign posts to wards and Departments)
- Access and booking
- Cancelled operations
- Patient transport

Staff and patient representatives contributing to QIS Strategy have outlined their concerns about the approach and communication from staff on the front line which they feel has led to a lack of consistency in care delivery. They have outlined that

- Verbal and written communication must be a priority for improvement so that the individual needs of the patient are core to how we professionally communicate as individuals and within clinical teams.
- They have emphasised the importance of the role of the ward manager and Matron in supervising care delivery but importantly to be a strong and visible leader with whom patients and carers can easily discuss any concerns and improvements made where required.
- However, they have identified a need for greater focus on all the interlinking dimensions to Quality through clinical leadership and performance management.

7.8 Actively engaging patients, staff and other key stakeholders on Quality

We recognise that our staff survey as well as our inpatient and Outpatient survey indicates the improvements required. In response to these concerns and in order that we agree ambitious improvement targets, public, patient and staff engagement commenced in 2011 with significant engagement and contribution to the development of the QIS strategy. This includes a "Listening into action" programme (LiA), LIPS (Leading Improvements in Patient safety) programme and quality improvement workshops.

In these engagement processes we asked patients and staff what was important to them in ensuring high quality services for all. Many of the aspects of their views have been integrated into the quality improvement strategy. A summary of the key themes which emerged from that engagement can be accessed on our web site under Quality Improvement.

The Quality Improvement Strategy makes a commitment and signals an even higher level of engagement and involvement with patients, community partners and stakeholders in supporting the redesign and transformation of services. This will be achieved by integration of quality improvements with ongoing development and implementation of the Trust's Patient Experience and Involvement Panel (PEIP) work programme. The work programme will cover Outpatient areas, A&E, Theatres, Maternity and Inpatient areas.

Detailed Quality Improvement objectives for patient experience, clinically effective and efficient care, and patient safety will be further developed with input from the Trust's Centre Chiefs, value Stream leads, clinical leads and audit and Outcomes team.

The Trust will continue to enhance the partnership work that it has built up over the last year with the Patients panel and with the Telford and Wrekin LINK, Shropshire LINK, and Montgomeryshire Community Health Council so that patients and patient and carer representatives are consistently involved in service redesign and are actively involved in the metrics approach to gaining patient experience from Outpatient areas, Departments and wards. The Trust will build on the methods of feedback and enhance the triangulation of themes and trends arising from those approaches.

As part of implementing the Quality Improvement Strategy we will investigate these themes further, using agreed patient feedback methodology including “Real Time” Monitoring to ask a high numbers of Outpatients and Inpatients about their immediate experience of care and services. If patients say they would recommend us to others we will ask why and for those who would not, we will also ask why and use the information to give feedback to staff and target our improvement efforts. The use of the Net promoter will be key to measuring confidence in the care we provide.

7.9 Metrics approach to care delivery – The Trust approach to putting patients first

The Trust Board recognizes that Quality and Safety are core aspects of the Boards agenda and that at least 25% of the agenda at the Board is focused on those aspects of the Trusts agenda. In the principles of putting patients first (one of the organizing principles of the Trust) a patient story is read out at the beginning of the private Board, Quality and Safety Committee and Hospital Executive committee. This process ensures that the emotions of this story resonate whilst the core business continues. The following methods to reviewing care will provide a metrics approach for Departments/ wards/ centres and corporate Committee’s to evaluate Quality care provision and performance.

7.10 Observations of Care

Observing care delivery in a ward and or Departments in teams of 2. Involves:
- Board members, Corporate nursing team, senior managers/Matrons, members of the Patients panel and Commissioners. Direct feedback of positive aspects of care as well as any issues which may need to be addressed will be given to the ward manager or nurse in charge with written feedback to the relevant clinical centre as well as a high level summary to the Quality and Safety Committee.

7.11 Patient Stories and Patient Diaries

Recruiting patients at the beginning of their patient pathway either in Outpatients or as an inpatient to share their story with us or use a Diary to record all aspects of their care, will be a core part of our improvement programme. Both processes will be used to evaluate and improve care delivery. This involves, Patient experience and involvement panel members (PEIP) who have received training on these principles; PALS, Patient services team, Corporate Nursing team, Matrons, LINKs, CHC and Commissioners. The themes from these stories will be triangulated with complaints and PALS/ real time patient feedback and fed back to wards/Depts within each relevant clinical centre and corporately collated so that emerging trends and themes for improvement are clear.

7.12 Themed patient panel reviews

When trends or themes appear the Trust will establish comprehensive panel reviews into those issues resulting in an internal report for consideration by the Hospital Executive Committee, Quality and Safety Committee and Board consideration when required. This will involve, Patient experience and involvement panel members (PEIP), LINKs, CHC, Corporate Nursing team, Clinical Matrons and Commissioners/ Education providers.

7.13 Real time patient feedback

Through an agreed template which has been designed to ask core open questions from patients during their Inpatient stay or in Outpatients/A&E and Maternity. This will illicit real time feed back and enable prospective

improvements to be made monthly this will reflect the progress being made on areas of improvement from the annual patient survey but also the top themes of concern from complaints and real time patient feedback as well as the “net promoter” questions on discharge. Ward managers, service area clinical matrons, PEIP members, Patient services team, corporate nursing team and Commissioners will be involved.

7.14 Ward to Board review

Core clinical (patient sensitive) indicators have been agreed for ongoing review as indicators of the effectiveness of care deliver. This provides information at ward or department-level as well as at Centre-level and Trust-wide to identify trends and themes. The information is gathered by ward

managers, matrons and senior nurses supported by PEIP members. Information gathered from this process is shared publically on each ward.

7.15 Quality Performance reviews

The Clinical Centres will all have a Quality performance review of these Indicators as part of their core Governance performance meetings. To maintain an overview of the overall and individual centre performance the Deputy Chief Nurse and Director of Finance will lead a monthly review of quality measures that demonstrate active performance towards quality improvement. This has a clear escalation process to the Chief Nurse when improvements are not made within agreed timescales and active performance management.

7.16 Patient environment action teams (PEAT) Inspections

Monthly reviews of patient environment take place to ensure that cleanliness, estate and facility issues are identified and improved. This involves PEIP members, members of the corporate nursing team, estates and facilities staff and the Infection Control team.

7.17 Patient Safety First reviews

The NPSA advocates “*Patient Safety first*” reviews of ward and department areas. A tool is available which enables Executive Directors and Non Executive Directors meeting with staff teams to discuss care delivery, the concerns about care delivery and support to progress. These reviews are now well established in the Trust with a summary of discussions and agreed actions fed back to the ward or department and to the Quality and Safety Committee.

7.18 Unannounced ward and Department reviews

Through our active monitoring and triangulation of key performance Indicators per ward and Department, we are now able to identify clinical areas which are cause for concern. In these circumstances we have over the last year undertaken detailed reviews of wards, some resulting in formal investigations into the concerns, remedial action plans or assurance provided. This process will now include patient or carer representation and commissioners/ Education providers and will progress onto a planned annual programme of review which will encompass all clinical areas and highlight the positive progress being

made by clinical areas as well as picking up areas for improvement where these have been evidenced through the review.

7.19 Quality and Safety Committee

The Quality and Safety Committee is a formal committee established by the Board to review all quality and safety issues in relation to performance. The Committee identifies trends and themes of issues with care delivery and raise any concerns with the Board. As part of this assurance process a 1 hour visit to a clinical area prior to the formal Committee business commencing is a formal part of the agenda with any issues from the visit being minuted.

7.20 Executive Directors- Clinical profile and support roles

The Executive Directors who are clinicians undertake clinical time with front line teams and ensure clear clinical leadership as well as clinical credibility. The corporate nursing and medical teams will also support this approach with all having 4 clinical sessions built into their job planning. Non-clinical Executive Directors support a wider profile in clinical areas through “buddying” arrangements with centres.

Please refer to our Quality Improvement Strategy (approved by the Trust Board on 29 March 2012) and our Quality Account (for presentation to the Trust Board by the end of June 2012).

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Section 8: Delivering Contractual and National Targets

- 8.1 Local Commissioners
- 8.2 Other Commissioners
- 8.3 Reconciliation Process
- 8.4 Internal Performance Management Arrangements
- 8.5 Provider Management Regime

8.1 Local Commissioners

Contracts have been agreed with our main commissioners with the exception of Powys LHB (see section 5.3 above). The contracts identify the detailed activity numbers that have been commissioned, including :-

- Elective inpatient and daycase spells (by HRG)
- Emergency and maternity spells (HRG)
- Consultant new, follow-up and procedure outpatient attendances (specialty)
- A&E attendances
- Direct access activity (eg radiology, physiotherapy)
- Other non-consultant led activity (eg nurse led, community midwifery).

The contracts also incorporate a set of schedules detailing both nationally mandated and locally agreed quality and performance targets, together with contractual consequences/penalties if these are not achieved. There are a range of these contained within the contract, including :-

- Nationally mandated 'never' events (non-payment)
- Nationally mandated infection control, cancer, 18-week and A&E targets (financial penalties)
- SHA mandated targets including reduction in pressure sores (range of penalties from improvement notices to financial)
- Locally agreed measures including a number of Stroke targets (failure to improve performance may result in withholding of payment)
- Screening programme targets such as bowel screening (possible improvement notices and withholding of payment)

Both formal performance review and clinical quality review meetings are held with our 2 local commissioners on a monthly basis. Where necessary, specific 1-off meetings or 'task and finish' groups are arranged with representatives from the commissioners and the Trust's clinical centres to discuss areas of concern and/or where performance is below target, to agree and monitor corrective action plans. These are fed back into the formal review meetings as appropriate. As previously indicated, both local commissioners are also

represented on the Trust's RTT delivery group, which meets on a weekly basis.

8.2 Other Commissioners

Monthly contract review meetings are held with Powys LHB. On an ad-hoc basis (2-3 times per year) there are also clinical service meetings with the LHB. For these, representatives from the LHB attend the Trust on an 'all day' basis and meet with representatives from the Trust's clinical centres to discuss specialty-specific issues.

Regular contract review meetings are held with the Trust's other commissioners, e.g. Specialised Services. Clinical centre representatives attend these as required.

8.3 Reconciliation Process

The contract agreement places a requirement on both our commissioners and the Trust to ensure a monthly activity and financial reconciliation takes place. There is an agreed timetable (contained within the contract documentation) for data submissions, queries to be raised and responded to, data to be resubmitted and month-end figures to be signed-off or escalated for resolution.

8.4 Internal Performance Management Arrangements

During the course of 2011/12 the Trust undertook a major management restructuring, creating 11 Clinical Centres and putting clinical leadership at the heart of decision making (each Centre is represented by its Centre Chief – a clinician – on the Trust's Hospital Executive Committee).

As the Centres mature the Trust is in the process of reviewing and strengthening its performance management processes. A key part of this will be the development of 'performance and accountability' agreements for each of the centres. These will detail both the expectations that the organisation requires of each centre and also the support the centres can expect from the corporate departments. These expectations placed on the centres will cover a range of issues but will include delivering planned activity levels, living within the resources available and delivering against national and locally agreed performance targets. The intention is that the centres formally sign-off the agreements.

Alongside this, the Trust has instigated monthly review meetings with each of the Centres (they began in January 2012, initially in 'shadow' form going 'live'

in April 2012. These are chaired by the Director of Operations and from a corporate perspective are also attended by the Finance and Workforce Directors. Other Directors may also attend. The Centres are represented by the Centre Chief and Manager, supported by their respective finance and workforce colleagues. Review packs containing key performance measures across finance, workforce, quality and national targets are produced prior to the meetings and form the basis for the discussions. The review packs will be refined during the first quarter of 2012/13 following review and to reflect feedback received from the centres.

all domains of the Provider Management Regime both to ensure consistently high standards of patient care and to support our aspirations to become an NHS Foundation Trust by 2014,

8.5 Provider Management Regime

Since the beginning of January 2012 the Trust, as per SHA requirements, has been completing the Provider Management Regime (PMR) template issued by the SHA. The PMR has 7 sections, namely:-

- Governance Declaration
- Governance Risk Rating
- Financial Risk Rating
- Financial Risk Triggers
- Contractual Risk Rating
- Quality
- Board Statements

The PMR provides a formal RAG Rating for the Governance Risk Rating, Financial Risk Rating and Contractual Risk Rating. A summary of these scores for the templates submitted during Quarter Four 2011/12 is as follows:

	Jan 2012	Feb 2012	Mar 2012
Financial Risk Rating	Green	Amber	Amber
Governance Risk Rating	Red	Red	Red
Contractual Risk Rating	Green	Green	Green

A summary of the Board Statements is included within Section 13 (Declarations)/ The full PMR returns are presented to the Trust Board alongside the Integrated Performance Report. A summary of performance against key national targets during 2011/12 is included at section 3.1. Our goals and objectives for 2012/13 will support sustained improvement across

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Section 9: Financial Plans



9.1 2011/12 Financial Performance

Overview

A detailed review of the underlying financial position of the Trust by the newly appointed Finance Director, subsequently validated by PricewaterhouseCoopers, identified that a recurrent deficit had been brought forward into the 2011/12 financial year, amounting to £14.4 million. Given the scale of this deficit, despite the actions being taken to deliver cost savings by the Trust in the 2011/12 year, it was recognised that in order for a balanced Income and Expenditure position to be achieved it would be necessary for the Trust to receive external non recurrent financial support from the West Mercia Cluster amounting to £6.5 million.

In setting a plan for the Trust the principal objectives were to:

- address the recurrent financial deficit and establish plans to deliver financial savings for the period 2012/13 to 2015/16 that enable the Trust to maintain a sustainable recurrent financial position, whilst *at the same time*;
- ensure delivery of a balanced Income and Expenditure position in the 2011/12 year; and begin the process of improving the liquidity position of the Trust

In delivering this financial plan the Trust has however also been required to respond to a series of significant operational performance issues, most notably by:

- addressing a significant waiting list backlog and a “hidden” backlog arising from the existence of a suspended waiting list. This has involved additional payment to our own staff and external organisations to create capacity to reduce the backlog from 22% of the total list in July 2011 to 6% in March 2012, in line with the national framework
- establishing new working practices to improve operational flow through the two hospital sites so as to enable the A and E attendances to be delivered with the 95 per cent target, enable cancer waiting time targets to be achieved and ensure

that a sustainable waiting list position is able to be delivered; *and*

- improving the quality of care provided by the Trust, with the stated aim of reducing the number of deaths within the two hospitals and improving the HSMR rate. Significant steps to achieve this have already been taken

Income and Expenditure position

Performance within the 2011/12 year is summarised as follows:

Table 9-1: Planned v Forecast I&E 2011/12

	Plan £m	Forecast £m	Variance £m
NHS Clinical Income	260.8	267.9	7.1
Other income	22.3	22.4	0.1
Financial support	6.5	6.5	-
TOTAL INCOME	289.5	296.8	7.3
Pay Costs	(198.6)	(199.4)	(0.8)
Non Pay Costs	(76.3)	(82.6)	(6.5)
TOTAL EXPENDITURE	(274.8)	(282.0)	(7.2)
EBITDA	14.7	14.8	0.1
Depreciation and Dividends	(14.7)	(14.7)	-
SURPLUS/ (DEFICIT) before Impairments	-	0.1	0.1
Fixed Asset Impairment		(1.0)	(1.0)
Surplus / (deficit) after Impairment		(0.9)	(0.9)
EBITDA Margin %	5.1%	5.0%	(0.1)%

The level of Income generated by the Trust within the year exceeded budget by £7.3 million. This achievement arose because of:

- a marked change within the case mix of patients treated within the hospital has led to over performance within contracts;
- activity associated with addressing the over 18 week backlog; and
- increased charges relating to High Cost Drugs

Reduction of the over 18 week backlog required the Trust to put into place increased capacity within the two hospital sites and also to purchase external capacity, particularly in respect of Orthopaedic activity, from local external providers. This led to an increase in pay costs to Clinical and Non Clinical staff. In addition to ensure the safe delivery of particularly unscheduled care the Trust has been required to put in place temporary staffing. These staff attract a significant pay premium.

The increased usage of High Cost Drugs, particularly in the treatment of Cancer and Ophthalmology patients, exceeded levels as specified within the local Health Economy. Such increased costs are recovered from the local commissioners. The actions taken to reduce waiting times also increased non pay costs as the Trust purchased enhanced levels of additional theatre capacity from the local Nuffield Hospital.

9.2 Cost Improvement Programme

The delivery of the Income and Expenditure plan required the Trust to take forward a Cost Improvement Programme delivering savings in the year amounting to £6.9 million. The Trust expected to deliver savings in the year amounting to £7.2 million with a full year effect of £13.1 million.

The Trust's programme of cost improvement has been delivered through the Programme Management Office, with each scheme having clear deliverables, lines of responsibility and monitoring mechanisms through the Finance & Performance Committee and Hospital Executive Committee. Each scheme has a standardised structure and project documentation and a Quality Impact Assessment (QIA) is undertaken against each scheme

Table 9-2: Cost Improvement Programme 2011/12

	Plan	Forecast	Recurrent FYE
	£m	£m	£m
Ward Closures	1,542	474	4,867
Medical staffing Agency spend	250	1,623	2,851
Reduce developments	1,632	1,941	1,903
Coding		649	1,200
Pharmacy	705	705	485
Income changes	800	400	300
Procurement	600	624	624
Estate review	300	-	-
Private Patients	250	250	250
Other	802	579	579
Total	6,881	7,245	13,059

9.3 Financial Indicators

i) Capital Resource Limit

The Capital Resource Limit for the Trust in the year 2011/12 amounted to £10.2 million. Spending within the year was expected to equal £9.2 million.

The Trust is presently developing plans for the sale of Assets, which are anticipated may take place in the 2012/13 financial year.

Significantly, as a consequence of implementing International Financial Reporting Standards (IFRS) the Trust has been required to consolidate Donated Assets into the overall Balance sheet of the Trust.

Table 9-3: Balance Sheet (Variance from 2010/11 to 2011/12)

	2010/11	2011/12	2011/12	Variance
	£m	Plan	Forecast	£m
		£m	£m	
FIXED ASSETS				
Tangible & Intangible Assets	159.6	154.1	159.6	(5.5)
CURRENT ASSETS				
Stock and Work in Progress	4.7	4.7	4.7	-
NHS Trade Debtors	7.5	7.5	7.5	-
Non NHS Trade Debtors	2.1	2.1	2.1	-
Other Debtors	0.2	0.2	0.2	-
Accrued Income and prepayments	2.9	2.9	2.9	-
Cash	0.2	0.2	0.2	-
Total Current Assets	17.6	17.6	17.6	-
CURRENT LIABILITIES (amounts due in less than one year)				

	2010/11	2011/12	2011/12	Variance
	£m	Plan	Forecast	£m
		£m	£m	
Trade Creditors	(8.9)	(6.7)	(11.2)	(4.5)
Other Creditors	(6.0)	(6.0)	(6.0)	-
Capital Creditor	(2.2)	(2.2)	(2.2)	-
Accruals and deferred Income	(10.4)	(7.1)	(7.1)	-
Total Current Liabilities	(27.5)	(22.0)	(26.5)	(4.5)
NET CURRENT ASSETS/ (LIABILITIES)	(9.9)	(4.4)	(8.8)	(4.5)
Long Term Debtors	-	-	-	-
TOTAL ASSETS LESS CURRENT LIABILITIES	149.7	149.7	150.9	1.2
Long Term Creditors	(0.5)	(0.5)	(0.5)	-
TOTAL ASSETS EMPLOYED	149.2	149.2	150.4	1.2
TOTAL LOANS				
TAXPAYERS EQUITY				
Public Dividend Capital	143.6	143.6	145.6	2.0
Income and Expenditure Reserve	(35.3)	(35.3)	(30.4)	4.9
Revaluation Reserve	35.5	35.5	35.2	-
Donated Asset Reserve	5.5	5.5	-	(5.5)
Other Reserves				
TOTAL TAXPAYERS EQUITY	149.2	149.2	150.4	1.2
TOTAL FUNDS EMPLOYED	149.2	149.2	149.2	-

Table 9-4: Cash position (Plan v Forecast Cashflow) 2011/12

	Plan £m	Forecast £m	Variance £m
EBITDA	14.7	14.7	-
Non Cash I&E Items	(0.7)	(0.7)	-
Movement in Working Capital	(5.5)	(1.0)	(4.5)
Cashflow from Operations	8.5	13.0	(4.5)
Capital Expenditure	(7.2)	(9.2)	2.0
Asset Sales	4.5	0.0	4.5
Cashflow before Financing	5.8	3.8	2.0
Interest (paid) on loans and leases	0.0	0.0	-
Interest(paid)/recd on cash balance	0.0	0.0	-
Movement in Loans	0.0	0.0	-
Movement in Public Dividend Capital (PDC)	(0.7)	1.3	(2.0)
Movement in Other grants/Capital received	0.0	0.0	-
Dividends Paid	(5.1)	(5.1)	-
Net Cash inflow/(outflow)	0.0	0.0	-
Opening Cash Balance	0.4	0.4	-
Closing Cash Balance	0.4	0.4	

During the 2011/12 year the Trust received an injection of PDC Funding associated with the reconfiguration project. This funding has been used to support increased capital expenditure in the year.

Table 9.5: Capital Spending Position (Plan v Forecast Capital Expenditure) 2011/12

	Plan £m	Forecast £m
Source of Funds:		
Operating Cashflow	8.2	8.2
PDC received	0.0	2.0
Loans and Leases	0.0	0.0
Cash receipt from asset sales	0	0
Total Sources	8.2	10.2
Application of Funds:		
Reconfiguration Costs	1.0	1.7
LINAC Replacement		2.3
Decontamination	0.9	0.6
Patient Monitoring equipment	0.3	0.3
Telecommunications system	0.4	0.4
Patient Status at a Glance	0.5	0.5
Maternity Theatre	0.7	0.2
Replacement Equipment /Backlog Maintenance	3.0	2.6
Ward closures		0.4
Other schemes	0.4	0.4
Total Applications	7.2	9.2

The Trust commenced the 2011/12 financial year with a Capital Resource Limit of £8.2 million. As part of a series of measures to strengthen the Balance sheet of the Trust it was decided to limit capital spending within the year to £7.2 million so enabling a sum amounting to £1.0 million to be used to improve the working capital position of the Trust. During the year the Trust Capital Resource Limit has been increased by £2 million. This sum being associated with the reconfiguration of services across the two hospital sites.

An Outline Business Case (OBC) supporting the reconfiguration project was approved by the SHA in September 2011 and a Full Business Case was approved by the SHA in May 2012. Approval of the Full Business Case enables the Trust to receive full funding amounting to £35 million to enable significant capital redevelopment to take place at the PRH site, incorporating a newly developed Maternity and Paediatrics facility and essential alterations to be made at the RSH site to ensure the clinical viability of services.

In recognition of the scale of development planned in respect of Maternity services at the PRH it was capital expenditure relating to Theatre facilities supporting Maternity care was restricted to the purchasing of portable equipment capable of being transferred for use in the new facility once established at PRH. Doing so reduced spend previously earmarked to upgrade Maternity Theatres at the RSH site by £500,000.

Within the 2011/12 year the Trust also committed to the purchase and implementation of a LINAC. This being necessary because one of the two existing LINACs is due for replacement in the 2012/13 year. The cost of the programme is £2.7 million, with £2.3 million spent in the 2011/12 year.

9.4 Long Term Financial Plan

9.4.1 Financial Strategy

The assumptions used and the approach to preparing the Long Term Financial Plan are key to both understanding the plan and also evaluating its robustness. It describes how the Trust intends to proceed over the next five years in respect of:

i) Clinical Services Development/Strategy

The trust has identified five key service development plans
Capital/Estates planning:

- Reconfiguration of Acute Surgery and Women & Children's Services
- Expansion and development of Cancer Services
- Development of Cardiology Services
- Expansion of Private Practice through joint venture arrangements
- Repatriation of market share

ii) Capital / Estates planning

We are developing an Estates Strategy that reconfigures all of the planned service changes and will reflect the Trust's priorities. This is monitored through the Trust's Capital Planning Group, and reported through the Finance & Performance Committee

iii) Workforce changes

We are developing a Workforce Strategy to ensure a planned, yet visionary approach to the leadership of our workforce. We have workforce plans to support the Cost Improvement Programme (shown right in table xx)

Table 9-6: Cost improvement impact on staff groups

Cost Improvement Programme	Staff Group	Impact WTE	12/13 Saving £'000	Outcome
Nursing Review	Nurses	54	900	Redeployment into posts covered by bank/agency
Medical Staff	Consultants and SAS	10	1000	Savings achieved through job planning
Bed Reduction Programme	Nurses and HCAs	64 Nurses 64 HCA Tot 128	3500	Potential redeployment
AHP Review	Physiotherapists Occupational Therapists	20	117	Potential redeployment
Estates and Corporate	Estates Personnel Managers	10 Estates 16 Corp Tot 16	800	Potential redeployment
Reduction of Temporary Staff	Various Administration Management Nurses Medical Records	160	4030	End of fixed term contract
Booking and Scheduling	Booking Clerks Administrators	39	142	Potential redeployment
Total Impact		427	10,489	

9.5 Key Assumptions in the Base Case

9.5.1 Activity

During 2012/13 there is a planned reduction in activity through the delivery of QIPP initiatives that equates to £5.3m (£8.8m fye). The Trust is committed to playing its part in delivering these initiatives and is in discussion at a clinical level on how to take these forward.

The Local Health Economy has commissioned external Consultants to undertake an exercise to enable a revised system plan to be constructed. In the construction of this plan it will then be possible to determine the extent of commissioner plans in respect of the transfer of care from hospital into the community and the scale of activity planned to be avoided within the two Hospital sites as a result of new hospital avoidance schemes. This work is due to be completed in June.

Given the absence of these plans, in the construction of the Base Case Financial model, the Trust has developed a view of the future based upon:

- existing recurrent activity levels, (as determined through a jointly developed PCT/SATH activity model);
- adjusted by a negative 1.1 percent as detailed in the recently published Tariff for 2012/13; and
- inflated by 1.2% to cover the estimated growth in activity as a consequence of demographic changes as previously notified to the Trust by the local PCTs.

A summary of activity by activity type is shown in table 9-7

Table 9-7: Summary of activity 2012/13 to 2016/17

	2012/13	2013/14	2014/15	2015/16	2016/17
Elective (Spells)	54.2	54.9	55.7	56.4	57.2
Non Elective (spells)	48.0	48.6	49.3	50.0	50.6
Total Admitted Patient Care (Att)	102.2	103.6	105.0	106.4	107.8
Outpatient (Att)	329.0	333.4	337.9	342.5	347.1
A&E (Att)	110.6	112.1	113.6	115.1	116.7

The above table does not allow for activity reductions associated with the local commissioner QIPP schemes planned for implementation in the 2012/13 year. This is so because local commissioners are continuing to undertake work to finalise their schemes and the attributable activity reductions.

9.5.2 Income Inflation

Table 9-8: Income inflation assumptions (%) 2011/12 to 2015/16

	2012/13	2013/14	2014/15	2015/16	2016/17
Clinical Income Inflation					
• NHS Tariff	(1.1)%	(1.8)%	(1.8)%	(1.8)%	(1.8)%
• NHS Non Tariff	(1.8)%	(1.8)%	(1.8)%	(1.8)%	(1.8)%
• Non NHS	(1.8)%	(1.8)%	(1.8)%	(1.8)%	(1.8)%
Other Income	0.0%	0.0%	0.0%	0.0%	0.0%
• Education & training	0.0%	0.0%	0.0%	0.0%	0.0%
• Research & Development	0.0%	0.0%	0.0%	0.0%	0.0%

The Trust has evaluated the impact of the 2012/13 published tariff and concluded that the impact is to reduce Income in the year by 1.1%. The impact as described within the Operating Framework had been computed to reduce income by 1.8%.

In addition to the National Tariff, the Trust has also recognised within the 2012/13 year, further reductions impacting upon the Income base of the Trust. These adjustments being in respect of:

- Readmissions – It has been confirmed by the Department of Health that the Acute sector needs to plan for a loss of Income associated with Elective and Non Elective readmissions Activity. Doing so reduces Income by a further 0.8%; and

- Local QIPP – Local Commissioners have confirmed an intention to reduce Income performed within the Trust as a result of Initiatives being taken forward to control activity. These schemes reduce Trust Income by 2.1%

9.5.3 Cost Inflation

Table 9-9: Cost inflation assumptions (%) 2012/13 to 2016/17

	2012/13	2013/14	2014/15	2015/16	2016/17
	£m	£m	£m	£m	£m
Pay	2.0%	2.0%	2.0%	2.0%	2.0%
Drugs	4.5%	4.5%	4.5%	4.5%	4.5%
Clinical supplies and services	4.5%	4.5%	4.5%	4.5%	4.5%
Non-pay	4.5%	4.5%	4.5%	4.5%	4.5%
Aggregate Inflation	2.6%	2.7%	2.7%	2.7%	2.7%

9.5.4 Combined Inflation / Efficiency Impact

Taking the consequences of Income inflation and Cost Inflation assumptions into account, this then places upon the Trust the following efficiency savings requirement over the years 2012/13 to 2016/17.

Table 9-10: Combined savings requirement 2012/13 to 2016/17

	2012/13	2013/14	2014/15	2015/16	2016/17
Income – Base Income	(1.1)%	(1.8)%	(1.8)%	(1.8)%	(1.8)%
Income – readmissions adjustment	(0.8)%				
QIPP schemes	(2.1)%	(1.1)%			
Expenditure	2.6%	2.7%	2.7%	2.7%	2.7%
Aggregate Efficiency impact	6.6%	5.6%	4.5%	4.5%	4.5%

9.5.5 Savings/Efficiency Requirements

In setting a plan for the years 2012/13 to 2016/17 the Trust has identified a requirement to generate the following savings / efficiency savings.

Table 9-11: Financial savings requirement 2012/12 to 2016/17

	2012/13	2013/14	2014/15	2015/16	2016/17
	£m	£m	£m	£m	£m
Recurrent	28.8	2.6	6.8	7.5	7.6
Slippage – Non Recurrent schemes	(13.5)				
Total	15.1	4.3	6.8	7.5	7.6

The total recurrent savings to be delivered within the Trust over the period then amounts to £53 million.

In response to this challenge the Trust has developed a comprehensive programme of cost improvement, and an overview can be seen on table 9-12 (overleaf).

Table 9-12: Cost Improvement programme 2012/13 – 2016/17

CIP Description	2012/13			2013/14			2014/15			2015/16			2016/17		
	Rec	Nrec	Total	Rec	Nrec	Total	Rec	Nrec	Total	Rec	Nrec	Total	Rec	Nrec	Total
Medical / Consultants	-3500	2500	-1000			0			0			0			0
WLI Payments	-1000	0	-1000			0			0			0			0
Nursing	-1600	700	-900			0			0			0			0
Bed Reductions	-3500	2625	-875			0			0			0			0
Procurement and non pay reduction	-4405	1000	-3405	-1500		-1500	-1500		-1500	-1500		-1500	-1500		-1500
Theatre cost reductions	-1000	833	-167			0			0			0			0
Diagnostic tests	-600	450	-150			0			0			0			0
Pathology	-1300	1300	0			0			0			0			0
Admin and Outpatients	-1700	1559	-142			0			0			0			0
Allied Health Professionals	-700	583	-117			0			0			0			0
On call Payments	-1000	500	-500			0			0			0			0
Estates / Corporate services	-800	400	-400			0			0			0			0
Repatriation - Cardiology			0			0	-500		-500	-600		-600			0
Radiology - Direct Access Income			0			0	-400		-400			0			0
Private Patient Income			0			0	-1000		-1000	-500		-500			0
Welsh Patients Income			0			0			0	-500		-500			0
Community hospital repatriate			0			0	-500		-500			0			0
UHNS Collaboration			0			0			0	-500		-500			0
Service Reviews - QIPP	-1700		-1700	-1100		-1100	-2900		-2900	-3900		-3900	-6100		-6100
Coding Improvement	-1000		-1000			0			0			0			0
VAT - Agency costs		-300	-300			0			0			0			0
Temporary Post reduction	-5040	740	-4300			0			0			0			0
2011/12 CIP schemes slippage		670	670			0			0			0			0
Total CIP	-28845	13560	-15285	-2600	0	-2600	-6800	0	-6800	-7500	0	-7500	-7600	0	-7600

(Values in the above table are 2012/13 price base)

Contained within the CIP Plan are substantial levels of savings associated with Local QIPP schemes. In order for such savings to be achieved it is necessary for structural changes to be introduced across the health economy, to enable the Trust to reconfigure service delivery.

In support of the delivery of the savings programme, the Trust has established a Programme Management Office to review progress of the schemes being delivered. The Programme Management Office reports directly into the Hospital Executive Committee and the Finance and Performance Committee of the Trust.

Each specific area of cost improvement has underpinning Programme Initiation Documents (PIDs) and an Executive Sponsor to provide support to a Programme Lead.

9.6 Working Capital Facility

A Foundation Trust applicant is required to have in place sufficient working capital for its first year of operation. A Working Capital Facility (WCF) could be considered similar to an overdraft facility but Monitor mandate that the facility must be committed and not repayable on demand which is in contrast to an overdraft facility. Monitor guidance further mandates that the facility can only be used in the context of the Trust's working capital requirements and should be employed as if part of its permanent borrowings. The facility has been modelled on 2011/12 recurrent cost base to meet the requirement of 30 days worth of operating expenditure. The Trust has still to commence formal negotiations for its WCF. A £23 million facility will be required.

Table 9-13: Working Capital Facility

Base Year	Expenditure				Facility required
	Pay	Non-Pay	Total	per day	
2011/12	(197.6)	(85.3)	(282.9)	(0.8)	(23.0)

9.7 Private Patients

Table 9-14: Private practice income 2012/13 to 2016/17

	2012/13	2013/14	2014/15	2015/16	2016/17
	£m	£m	£m	£m	£m
Private Patient Income	2.078	2.078	3.078	3.578	3.578

The Trust is presently developing a strategy for increasing the level of Income generated by the Trust in respect of Private Patients. In developing the medium term financial plan a prudent assumption has been made in respect of the pace of growth of such Income. As such the level of Private Patient Income is expected to remain constant in the years 2012/13 and 2013/14 at levels consistent with the level of Income generated in the 2011/12 financial year. In 2014/15 as the Trust implements a revised Private Patient strategy Income is planned to grow to £3.078 million and by a further £500,000 in the 2015/16 year.

9.8 The Base Case Financials

9.8.1 Income and Expenditure

The base case Income and Expenditure projection along with the items that create the 'Normalised position' for the period 2011/12 to 2016/17 are shown in the table below.

Table 9-15: Base Case Income and Expenditure 2011/12 to 2016/17

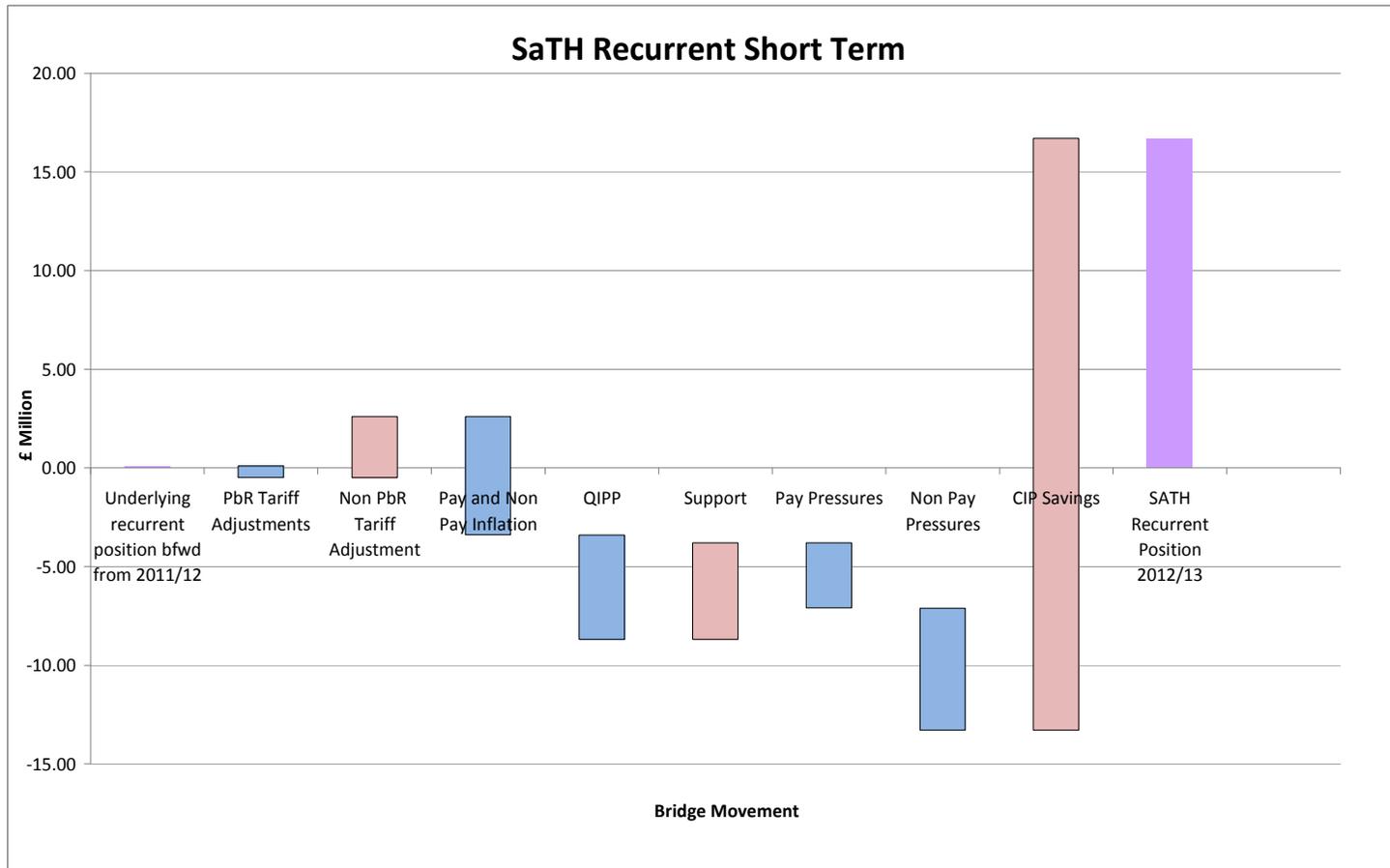
	2012/13	2013/14	2014/15	2015/16	2016/17
	£m	£m	£m	£m	£m
Total Income	297.1	289.1	288.3	287.1	285.9.
Total Costs	(280.9)	(270.8)	(269.7)	(268.3)	(267.1)
EBITDA	16.2	18.3	18.8	18.8	18.8
EBITDA Margin %	5.5%	6.3%	6.5%	6.6%	6.6%
Financing Costs:					
Profit / loss on asset disposals	0.0	0.0	0.0	0.0	0.0
Fixed Asset impairments	0.0	0.0	0.0	0.0	0.0
Depreciation & Amortisation	(9.2)	(10.1)	(10.1)	(10.1)	(10.1)
Interest receivable/ (payable)	0.0	0.0	0.0	0.0	0.0
Interest payable on Loans and leases	(0.0)	0.0	0.0	0.0	0.0
PDC Dividend	(5.2)	(5.9)	(6.1)	(6.2)	(6.2)
Net Surplus/(Deficit)	1.9	2.3	2.4	2.5	2.5
Normalised Net Surplus/(Deficit)	1.9	2.3	2.4	2.5	2.5
Transfer from Donated Asset Reserve	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)
Depreciation & Amortisation	9.2	10.1	10.1	10.1	10.1
Net interest receivable/ (payable)	0.0	0.0	0.0	0.0	0.0
PDC Dividend	5.2	5.9	6.1	6.2	6.2
Normalised EBITDA	15.4	17.4	17.7	17.9	17.9
Normalised EBITDA Margin %	5.5%	6.0%	6.2%	6.3%	5.3%

Note: Includes items which create normalised position

Bridge diagrams 2012/13

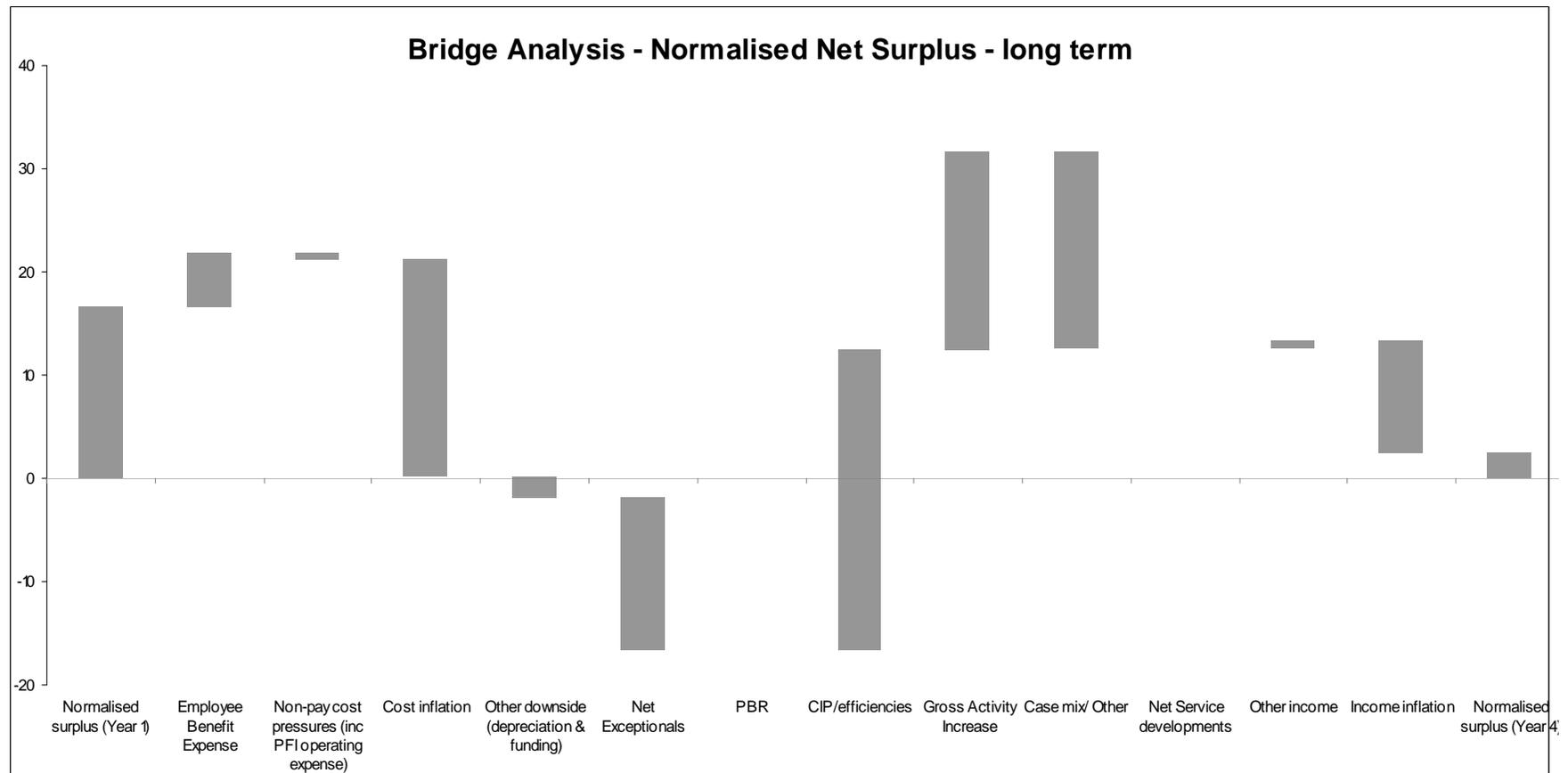
The bridge diagram provides a presentation of the recurrent position of the Trust in the 2012/13 year. As can be seen, the Trust commences the year with a balanced recurrent position and then needs to accommodate a substantial recurrent problem as a consequence of the application of a negative tariff, readmissions adjustment, pay and non pay inflation and income reduction arising from QIPP schemes developed by local commissioners. In response the Trust is taking forward a major recurrent Cost Improvement Programme that, once delivered, will enable the Trust to end the year with a recurrent surplus amounting to £16.7 million. Such a surplus is then being used to cover further income losses and inflationary pressures anticipated in the 2013/14 year.

Figure 9-1 Recurrent position 2012/13



The recurrent position as can be seen in the diagram below declines from a £16.7 million surplus at the beginning of the 2013/14 year and at the end of 2016/17 year the Trust has a recurrent surplus amounting to £2.5 million.

Figure 9-2: Normalised net position 2013/14 to 2016/17



9.9 Capital Programme

The Capital Programme is the key enabler for any Service changes planned by the Trust. The Capital Programme is managed through a Capital Planning Group (CPG) that meets monthly and reports to the Finance and Performance Committee. The planned programme is summarised in the table below.

In the 2012/13 year the Trust records an underspend in respect of the Capital Programme amounting to £5.5 million, this underspend is then used to improve the working balances of the Trust.

Table 9-16: Planned Capital Programme (£m) excluding Donated Assets 2012/13 to 2016/17

	2012/13	2013/14	2014/15	2015/16	2016/17
	£m	£m	£m	£m	£m
Source of Funds:					
Operating Cashflow	8.3	9.3	9.3	9.3	9.3
PDC received	33.0	0.0	0.0	0.0	0.0
Loans and Leases	0.0	0.0	0.0	0.0	0.0
Cash receipt from asset sales	4.5	0.0	0.0	0.0	0.0
Total Sources	45.8	8.3	8.3	8.3	8.3
Application of Funds:					
Reconfiguration project	33.0	0.0	0.0	0.0	0.0
LINAC Replacement	0.5				
Replacement equipment / Backlog maintenance	2.6	2.6	2.6	2.6	2.6
Information Technology	0.4	0.4	0.4	0.4	0.4
Other schemes	2.8	6.3	6.3	6.3	6.3
Total Applications	40.3	9.3	9.3	9.3	9.3

9.10 Balance sheet

Table 9-17- Balance Sheet Projections (£m) 2011/12 to 2016/17

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£m	£m	£m	£m	£m	£m
FIXED ASSETS						
Tangible & Intangible Assets	159.6	187.1	187.1	187.1	187.1	187.1
CURRENT ASSETS						
Stock and Work in Progress	4.7	4.7	4.7	4.7	4.7	4.7
NHS Trade Debtors	7.5	7.5	7.5	7.5	7.5	7.5
Non NHS Trade Debtors	2.1	2.1	2.1	2.1	2.1	2.1
Other Debtors	0.2	0.2	0.2	0.2	0.2	0.2
Accrued Income and prepayments	2.9	2.9	2.9	2.9	2.9	2.9
Cash	0.2	0.2	2.5	4.9	7.4	9.9
Total Current Assets	17.6	17.6	19.9	22.3	24.8	27.3
CURRENT LIABILITIES (amounts due in less than one year)						
Trade Creditors	(11.2)	(3.7)	(3.7)	(3.7)	(3.7)	(3.7)
Other Creditors	(6.0)	(6.0)	(6.0)	(6.0)	(6.0)	(6.0)
Capital Creditor	(2.2)	(2.2)	(2.2)	(2.2)	(2.2)	(2.2)
Accruals and Deferred Income	(7.1)	(7.1)	(7.1)	(7.1)	(7.1)	(7.1)
Total Current Liabilities	(26.5)	(19.0)	(19.0)	(19.0)	(19.0)	(19.0)
NET CURRENT ASSETS / (LIABILITIES)	(8.8)	(1.4)	0.9	3.3	5.8	8.3
TOTAL ASSETS LESS	150.9	185.7	188.0	190.4	192.9	195.4

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£m	£m	£m	£m	£m	£m
CURRENT LIABILITIES						
Long Term Creditors	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)
TOTAL ASSETS EMPLOYED	150.4	185.3	187.6	190.0	192.5	195.0
TAXPAYERS EQUITY						
Public Dividend Capital	145.6	178.6	178.6	178.6	178.6	178.6
Income and Expenditure Reserve	(30.4)	(28.5)	(26.2)	(23.8)	(21.3)	(18.8)
Revaluation Reserve	35.2	35.2	35.2	35.2	35.2	35.2
Donated Asset Reserve	0.0	0.0	0.0	0.0	0.0	0.0
Other Reserves	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL TAXPAYERS EQUITY	150.4	185.3	187.6	190.0	192.5	195.0

The key features of table 9-17 (above) include:

- Fixed Assets reduce in value in the 2012/13 year by £5.5 million because of a £1 million capital underspend and the sale of Assets valued at £4.5 million. From 2013/14 Capital spending has been set equivalent to the level of funds generated internally within the Trust through the depreciation of Assets.
- Fixed asset values increase by £33 million from 2012/13 funded through PDC.
- Cash balances increase by £9.7 million as a result of operating surpluses generated over the years 2013/14 to 2016/17
- Trade creditors reduce by £7.5 million in the 2012/13 year funded through cash receipts from the sale of assets (£4.5 million), capital underspending (£1.0 million) and operating surpluses of £2.0 million.

9.11 Cash Flow

Table 9-18: Cash Flow Projections (£m)

	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m
EBITDA	16.2	18.3	18.6	18.8	18.8
Non Cash I&E Items	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)
Movement in Working Capital	(7.4)	0.0	(0.0)	(0.0)	0.0
Cashflow from Operations	8.0	17.4	17.7	17.9	17.9
Capital Expenditure	(40.3)	(9.3)	(9.3)	(9.3)	(9.3)
Asset Sales	4.5	0.0	0.0	0.0	0.0
Cashflow before Financing	(27.8)	8.2	8.5	8.7	8.7
Interest (paid) on loans and leases	0.0	0.0	0.0	0.0	0.0
Interest(paid)/recd on cash balance	0.0	0.0	0.0	0.0	0.0
Movement in Loans	0.0	0.0	0.0	0.0	0.0
Movement in Public Dividend Capital (PDC)	33.0	0.0	0.0	0.0	0.0
Movement in Other grants/Capital received	0.0	0.0	0.0	0.0	0.0
Dividends Paid	(5.2)	(5.9)	(6.1)	(6.2)	(6.2)
Net Cash inflow/(outflow)	0.0	2.3	2.4	2.5	2.5
Opening Cash Balance	0.2	0.2	2.5	4.9	7.4
Closing Cash Balance	0.2	2.5	4.9	7.4	9.9

The cash position is key to the future viability and operations of the Trust. In order to maintain an adequate liquidity ratio, a working capital facility equivalent to 30 days operating expenditure will be required. However, given the cash surpluses forecast in the table above, this would not need to be drawn against. Surplus cash balances will be invested on a short/medium term basis in line with the Trust's future expenditure requirements and its Treasury Management Policy.

9.11.1 Financial Risk Rating (FRR)

The overall rating for each year of the plan is shown in the table below:

Table 9-19: Financial Risk Rating 2012/13 to 2016/17

	2012/13	2013/14	2014/15	2015/16	2016/17
EBITDA margin	5.5%	6.3%	6.5%	6.5%	6.5%
EBITDA, % achieved	100.0%	100.0%	100.0%	100.0%	100.0%
ROA	4.2%	4.4%	4.5%	4.5%	4.5%
I&E surplus margin	0.6%	0.8%	0.8%	0.9%	0.9%
Liquid ratio - days	11.0	21.3	24.5	27.8	31.3
Overall Risk Rating	2.0	3.0	3.0	3.0	3.0

Given these results, in successfully achieving the Long term Financial Plan, the Trust is then able to achieve a level 3 financial risk rating in each of the years 2012/13 to 2016/17. This is so because in failing to achieve a I and E surplus margin in excess of 1% of turnover the Trust is classified as having a risk rating of "2" against this indicator in each year. Having an indicator of "2" in any category means that the Trust is unable to score an overall performance in excess of 3.

Putting Patients First



Section 10: Workforce Plans

- 10.1 Background
- 10.2 Workforce Profile
- 10.3 Workforce Strategy
- 10.4 Health and Wellbeing
- 10.5 Absence Data
- 10.6 Staff Turnover
- 10.7 Recruitment Priorities
- 10.8 Appraisals
- 10.9 Staff Survey
- 10.10 Workforce Planning
- 10.11 Workforce Plans to support CIP
- 10.12 Workforce Transformation
- 10.13 Workforce and Organisational Development
- 10.14 Developing our Devolved Structure
- 10.15 Staff Engagement
- 10.16 Sharing Our Annual Plan

10.1 Background

We are ambitious to ensure that our organisation is a great place to work. We aim for our workforce to be our strongest ambassadors, they will be proud to work for our organisation for the care we will deliver. We are developing a Workforce Strategy to ensure a planned yet visionary approach to the leadership of our Workforce. The focus for the year ahead will be to improve the employment experience, the measure of our success will be significant improvement in our staff survey results.

10.2 Workforce Profile

In 2011/12 our workforce grew by 253 staff, bringing the number employed to 5390, Given that many of our staff work part-time this represents 4521 whole-time equivalent (wte). Expenditure on staff accounts for approximately 68% of our expenditure.

Our workforce at 31 March 2012 included:

- 513 wte doctors and dentists (11.3%)
- 1,366 wte nursing and midwifery staff (30.2%)
- 578 wte scientific, technical and therapies staff (12.8%)
- 1,213 wte other clinical staff (26.8%)
- 852 wte non-clinical staff (18.8%)

There are currently 522 volunteers active in the Trust and we work closely with our main charitable partners (including Leagues of Friends at our two main hospitals, WRVS and the Lingen Davies Cancer Appeal).

10.3 Workforce Strategy

The Trust is developing a Workforce Strategy and an Organisational Development Strategy that together will enable the organisation to achieve its vision. The foundation of the strategy is to embed our values in a meaningful way throughout the employment life cycle, thereby ensuring that our values are experienced through our employment decisions.

The organisational values are:

- Putting patients first – service to the patient above all else

- Honesty and integrity – dealing with the facts
- Being a clinically led organisation
- Working and collaborating together
- Encouraging individuality, ability and creativity
- Taking pride in our work and in our organisation

The strategies focus on the planning and development of a Workforce that is fit for purpose both now and for the future challenges the organisation will face.

10.4 Health and Wellbeing

The health and well-being of staff is imperative to ensure the delivery of safe and quality services to our patients. This means that as an organisation, we support staff to assess and take responsibility for their own health, as well as promoting healthy options and providing preventative services to our Workforce.

Informed by the 2009 Boorman Report we have developed an approach to Health and Wellbeing. We are proactive about the Health and Wellbeing of our Workforce, a wide range of initiatives have been implemented with a strong focus on engagement, recognition and empowerment. The benefits being:

Organisation Benefits:

- Help achieve our objectives and key performance indicators
- Provide independent support for staff through a time of significant organisational change
- Improve attendance at work, with an additional benefit of a reduced demand for Bank and Agency staff
- Reduction in sickness absence percentage
- Improved staff retention, reducing the cost of turnover and retaining skilled and experienced workers

Employee Benefits:

- Staff feeling that they are involved in decisions that affect them, both individually and through representatives.

- Increased morale and engagement with work
- Supporting staff in dealing with stressful situations more positively and effectively
- Reduced levels of stress and absence and improved health and wellbeing
- Through good communications support staff to understand and adapt to change easily
- Access to support to help staff keep themselves healthy and safe
- Promote a positive self image

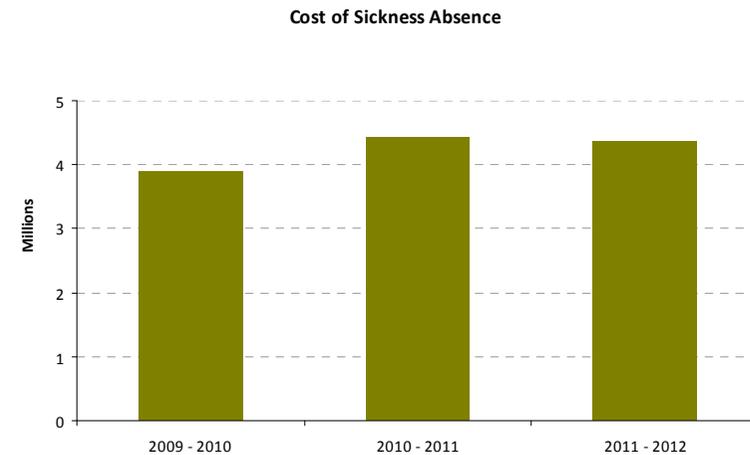
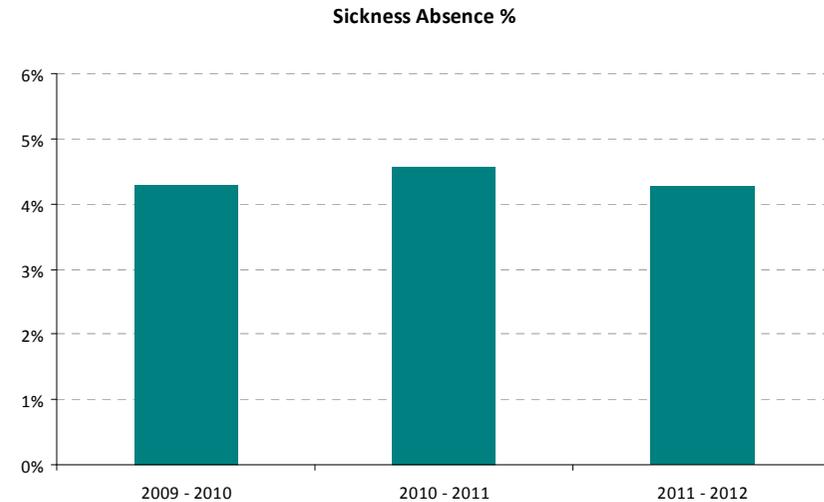
Our Health and Wellbeing objectives are included in our Workforce strategy, and include that we will:-

- Implement the recommendations of the Boorman review
- Embed a culture of staff feeling that the organisation actively promotes health and well-being.

10.5 Absence Data

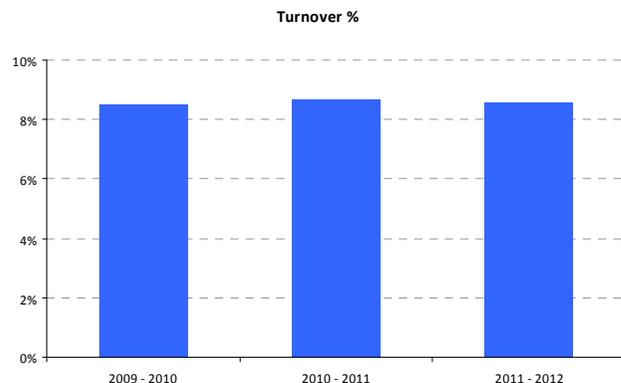
The Trust's sickness absence rate for the year to March 2012 is 4.28%, which is reduction on the previous year.

Absence creates both a quality and cost impact for the Trust and for our patients. The indicative annual costs are illustrated in the graph opposite. We will be ensuring a strategic approach to Health and Wellbeing that delivers an increase in staff satisfaction, a reduction in absence and therefore a reduction in costs and benefits for quality of care



10.6 Staff Turnover

Turnover has been at a steady rate over the last three years. A key aspiration for the year ahead is to seek to manage the required reduction in pay costs within turnover wherever possible.



10.7 Recruitment Priorities

In common with other acute providers we face challenges to sustain recruitment in some specialities. Key factors include availability of trained staff at a national level, which can be compounded by our rural location. Current recruitment priorities are set out in Table 10.7a.

Table 10.7a: Recruitment Priorities		
Role and Specialty	Timeline	Action Plan
Trainee & Middle Grade Medical Staff National employment market compounded by local rural location (e.g. specialist Registrars in general medical specialties; FY2 in Trauma & Orthopaedics; Middle Grade in Accident & Emergency, Trauma & Orthopaedics, Anaesthetics)	Ongoing	Continue to pursue recruitment through available means including offer of clinical fellowships.
Consultant Haematologist National employment market plus need for specialist skills (e.g. cytology) and risks to continuity relating to staff turnover	2014	Options regarding Cytology being considered including development of Advanced Practitioner role and recruitment of Biomedical Scientists
Consultant Radiologist (Breast)	Ongoing	Training Advanced

National employment market compounded by local rural location		Practitioners to undertake biopsies and film reading. Plans to train Consultant Radiographer (4 year programme)
Medical Staff – Anaesthetics Difficulties in attracting attract trainee and middle grade medical staff	Ongoing	International recruitment Flexible working options
Senior Pharmacists Attractiveness of career progression, changing workforce (80-90% of graduate pharmacists are female vs. current career model does not support good work/life balance) and market competition.	Ongoing	Developing relationships with universities, schools of pharmacy and medical schools, including funded teacher practitioner links.
Fertility Scientists National employment market compounded by local rural location	Ongoing	Appointment of trainees
Advanced Nurse Practitioners (Neonatal and Paediatrics) National employment market compounded by local rural location	Ongoing	Appointment of trainees
Women's Services Assistants Retention	Ongoing	Development of comprehensive training package
Sonographers Impact of training programme on service delivery	Ongoing	Two year in-house training programme developed. Utilise learning beyond registration.

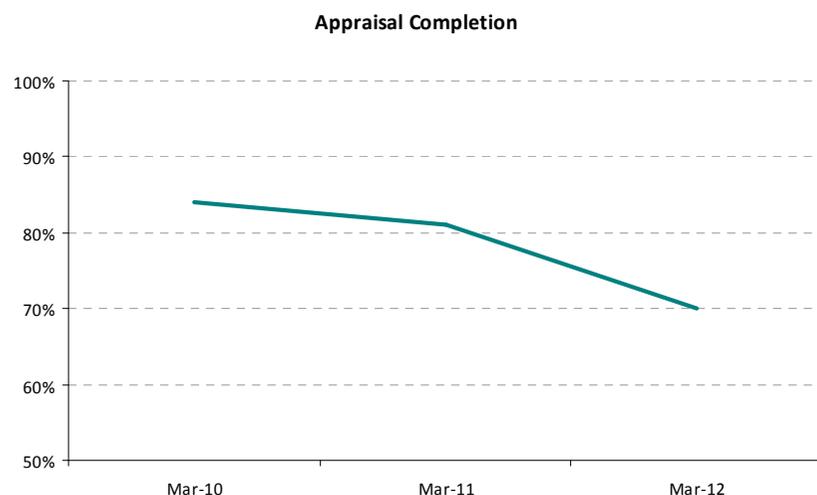
10.8 Appraisals

Following a period of sustained improvement until 2009/10 we have seen a decline in appraisal rates over the last two years, with the percentage of appraisals falling below our target of 80% in 2011/12.

Appraisal will continue to be a central measure in performance reviews for the new clinical centres, and now that these are fully established following our transition during 2011/12 we are confident that the new line management arrangements will ensure improvement. Centres are held to account for their

performance and agree improvement plans were performance drops below expected standards.

In the year ahead we are developing our appraisals framework with the aim of ensuring meaningful appraisals. We will also translate our values into competencies to begin to embed our values as behaviours that we all sign up to.



10.9 Staff Survey

Our Staff Survey results do not represent the employment experience we want our Workforce to have. Moving forward we will focus on what needs to take place to ensure our organisation is a great place to work and ensuring our staff deliver excellent patient care.

Our focus will be to ensure a positive employment experience, through a focused improvement in two areas: staff recommending the Trust as a place to receive care and staff recommending the Trust as a place to work. We aim to improve our results in this area by 10% each year for the next 5 years. Staff Conversations are being planned to better understand 'what would make

SaTH a great place to work?' Centres will then focus on improving employment experience. The Board is committed to change and through the Workforce Strategy believes improvement can be achieved.

10.10 Workforce Planning

The Trust is currently developing a more sophisticated approach to Workforce. With the appointment of a Workforce Planning and Transformation Manager in April 2012 this will strengthen our approach to workforce planning aligned with plans for the future delivery of care. Our priorities for the year ahead include strengthen the internal approach to talent development, particularly where we face future workforce challenges in relation to succession planning. Our approach will be to identify business critical roles and understand who the potential successors are to those posts and to identify the support needed to support progression..

10.11 Workforce Plans to support Cost Improvement Programme (CIP)

The Trust faces significant financial challenges during 2012/13 which will impact significantly on our workforce in a variety of ways – for example, given that two thirds of our expenditure is on pay costs then a reduction in our income in real terms will impact on the overall pay budget and therefore on staffing levels.

Overall plans are being developed as part of our Cost Improvement Programme, with our aim wherever possible to accommodate change through workforce turnover, redeployment and training. Central to these plans is a process of Quality Impact Assessment so that patient experience, patient safety and clinical effectiveness are not compromised.

10.12 Workforce Transformation

Over the coming year the Trust will deliver a number of transformation programmes all of which have workforce implications. The Full Business Case for the Future Configuration of Hospital Services was approved by the Trust Board in April and has been presented to the Strategic Health Authority for consideration. A key element of this programme is a Workforce Transformation. A number of elements of the Workforce Plan will begin this year to ensure effective workforce planning and management. This includes the planning and delivery of the first stages of the surgical reconfiguration.

In addition the organisation will also develop its approach to new ways of working such as Telehealth, and a comprehensive workforce development programme will support the Trust to ensure that benefits are realised.

10.13 Workforce and Organisational Development

As we move forward as an organisation we are clear on the direction we wish to take. In order to truly understand our organisation we are this year completing an Organisational Cultural Assessment¹, utilising the Cameron and Quinn Competing Values Tool. We aspire to have a culture centred on our patients in which our staff feel engaged, enabled and empowered.

The development of our Organisational Development Strategy will further develop our Leadership Development. It will set our approach for Talent Identification and development to support our organisation but also the wider NHS as we will be an organisation that nurtures talent and allows growth.

Our OD Strategy will ensure that we address our organisation as a whole to ensure that focus is given equally to behaviours, processes and structures.

Through a Learning Needs Analysis a need to develop business acumen has been identified. This has included the establishment of a new Leadership Academy in partnership with Warwick Business School to develop our senior clinical and corporate leaders. The programme is designed for Centre Chiefs and their teams and includes the key areas of:

- strategic leadership
- leadership behaviours
- culture change
- leading teams
- engaging staff and stakeholders

The programme, which offers 50 places to Senior Leaders, will be robustly evaluated, and uses the Competing Cultures Model (Cameron & Quinn) as an underpinning framework.

Recognising the significant impact of effective leadership at every level of the organisation, the Leadership Academy will deliver enhanced leadership skills and behaviours. Key early priorities are:

- Senior Clinical Leader Development (with Warwick Business School)
- Coaching Skills for Leadership (Level 7 accredited programme)
- Ward Manager Leadership Development (including accountability, leadership behaviours and coaching skills)
- Management Development (accredited programmes at team leader and supervisor levels).

10.14 Developing our devolved structure

With the development of our new approach to Devolution and Co-operation during 2011/12, we have continued to invest in the development of our organisational leaders to support devolved leadership. Regular meetings of the Trust Leadership Team take place, combining business and development sessions including:

- Telehealth
- Development of clinical leadership teams
- Strategy
- Financial Challenge
- Quality Improvement Strategy
- The relationship between centre's and corporate teams.

The programme for 2012/13 will include

- Leadership Development
- Professional Standards
- Reconfiguration of Services
- Organisational Development
- Strategic Development
- QIPP

The OD strategy is clear in its commitment to develop centres to ensure organisational success.

¹ Cameron & Quinn, 2009

10.15 Staff Engagement

Staff Engagement is an important element of our Workforce Strategy based on the overwhelming evidence on the difference it can make to key indicators such as HSMR and absence². The Trust has recently adopted 'Listening into Action' (an established model of staff engagement and empowerment that has been successful in a number of other NHS organisations). During 2011/12 the Chief Executive held staff conversations with over 400 staff to better understand what it is like to work here. Since the launch of this programme, over 80 staff have begun to work on enabling projects to start to empower staff to make changes for the benefit of patients, their colleagues and the organization.

To date ten projects have been identified as early enablers, including Women and Children's Centre who are engaging a wide range of internal and external stakeholders in improving their labour induction.

10.16 Sharing our Annual Plan with our staff

This Annual Plan has been informed and influenced by the feedback we have received from our staff and our Centres. Following approval by the Trust Board the plan will be shared with and implemented through our Clinical Centres and corporate teams and they will continue to shape its evolution and our plans for the future.

This includes delivering the Trust's strategy and objectives through Centre delivery plans and through individual objectives and appraisal.

² NHS Employers 2011

Putting Patients First



Section 11: Sustainability

- 11.1 Sustainable Development
- 11.2 Good corporate citizen
- 11.3 Carbon Reduction Commitment
- 11.4 Carbon Emissions
- 11.5 Examples of good practice

11.1 Sustainable Development

The Trust has made good progress in many areas of our sustainable development plan during the past 12 months. We have improved the measurement and recording of our building energy usage which helps us to identify when usage deviates from the norm and take steps to address this. A similar approach is being taken to water usage.

Sustainability issues are considered from the outset when planning new buildings. For example, the new Cancer and Haematology Centre Development at the Royal Shrewsbury Hospital incorporates a 'light well' to introduce natural light and ventilation into the core of the building. There is user-adjustable natural ventilation to the perimeter of the building and the lighting incorporates efficient T5 fluorescent fittings with light and movement detection.

Renewable energy options are being considered for the new facilities proposed for Telford, with possible integration of services to the existing building so as to give a more widespread improvement in energy efficiency. We are aiming for a BREEAM 'Excellent' rating for the new building.

In terms of educating our staff about environmental issues, we have produced some Green Pages on the intranet and are presently developing an e-learning package using bespoke examples of good practice around our hospital.

We have made a 'car-sharing' scheme available to staff and also have discounted bike offers for staff to use at local shops; hence creating a link with supporting the local economy.

In terms of reducing the carbon footprint of the products that we purchase, we have recently purchased a software system to identify our carbon hotspots. This will enable us to target these areas so as to manage our carbon footprint. The software has been developed in conjunction with the NHS SDU.

Future aspirations for sustainability include a further reduction in our carbon footprint arising from buildings (and occupation thereof), t

ransport and procurement.

The trust has also agreed with Shropshire Healthcare Procurement Service to adopt a partnership approach to sustainable purchasing, beginning with a system to take our procurement data and run it through an artificial intelligence spend analysis developed by Reading University and Goldsmiths College London to identify the controlled & uncontrolled spend.

Where there is purchase order line item detail, this will enable the calculation of the carbon footprint of each individual item by combining purchasing data with the Centre for Sustainable Accounting's carbon intensity figures.

By gaining understanding of where our carbon hotspots lie in terms of product, supplier and category, we should be able to start to look for alternative products and identify worst offending suppliers in terms of carbon footprint, and use our purchasing power to encourage more sustainable corporate behaviours.

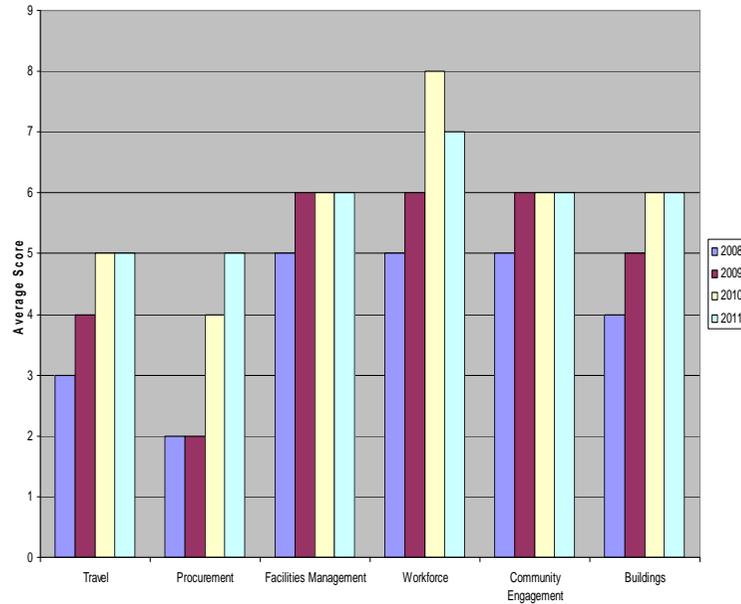
11.2 Good corporate citizen

The Shrewsbury and Telford Hospital NHS Trust is one of the largest employers in the county and a large user of resources. As such it can play a key role in the local community. The *NHS Good Corporate Citizenship Assessment Model*³ is central to achieving sustainable development. It is a web-based tool (www.corporatecitizenship.nhs.uk) designed to help NHS organisations assess and improve their contribution to sustainable development. The trust has been registered since 2008 and has seen steady progress. The Board receives an annual update on progress and agrees the priorities for the coming year.

The chart overleaf demonstrates our progress since we introduced the assessment model in 2008. We have made maintained or improved in all domains since 2010 with the exception of Workforce where we need to re-double our efforts to engage our workforce in sustainability issues.

Chart 1: NHS Good Corporate Citizen assessment 2008-2011

³ Taking Action on Climate change – Faculty of Public Health, NHS Confederation & NHS Sustainable Development Unit – August 2009



- Promote the work on Good Corporate Citizenship
- Develop an awareness-raising / training package regarding environmental and energy issues.

The full action plan will continue to be monitored through the Corporate Citizen Steering Group which meets quarterly and is available through the Director of Compliance & Risk Management.

11.3 Carbon Reduction Commitment – Energy Efficiency Scheme.

The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal. There is also a financial benefit which comes from reducing our energy bill.

Our total energy consumption has fallen during the year, from 74,947 to 71,823 MWh, and our relative energy consumption has also fallen, from 0.68 to 0.65 MWh/square metre. Whilst we do not have any specific contracts for renewable energy we generate 16% of our energy on site.

The priorities for the coming 12 months are:

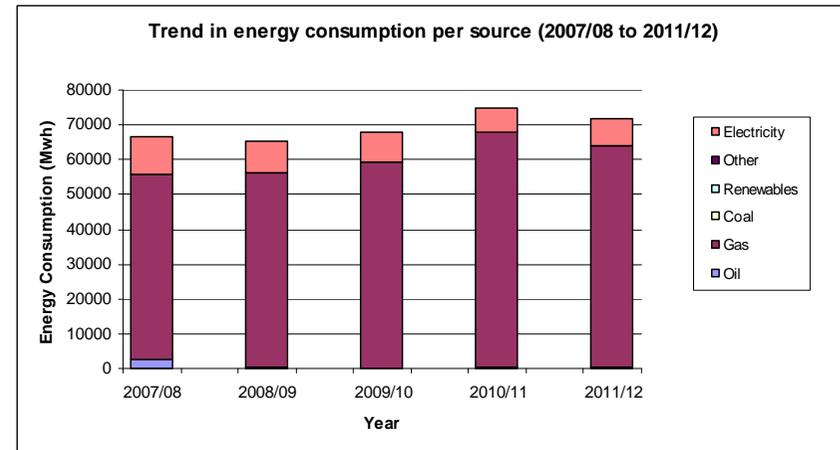
Estates and Transport:

- active travel (cycling, walking, public transport, car sharing etc) ,
- business travel (alternatives so as to reduce need for vehicle movements between sites for meetings)
- minimising usage of hazardous substances in Trust activities.

Procurement:

- re-write Procurement Strategy to include sustainability,
- promote sustainability to end-users,
- review possibility of making some sustainability criteria compulsory and
- consider approaches to enhance Supplier engagement.

Workforce and Engagement:

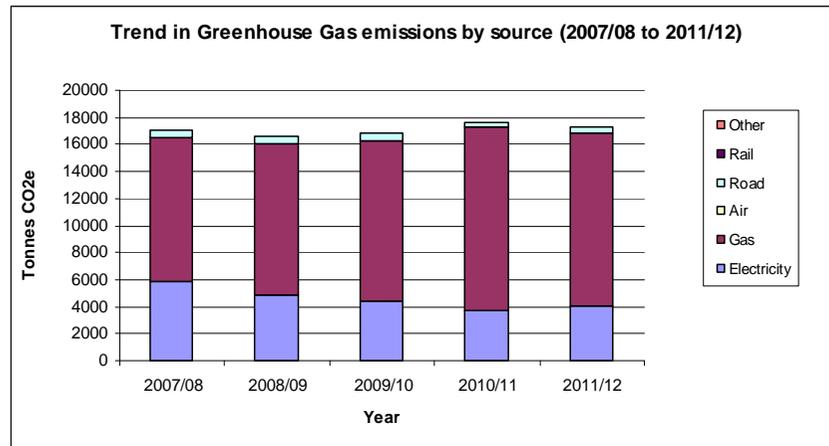


Despite reduction in energy usage, high levels of fuel inflation have meant that our energy costs have increased by 30% in 2011/12, the equivalent of 129 hip operations. However, they remain significantly below levels in 2007/08 following a number of successful initiatives to reduce energy costs including the Combined Heat and Power programme.

SaTH has already undertaken significant work to reduce the energy demand and carbon footprint of its buildings. This is reflected in the Trust's position in the Carbon Reduction Commitment (CRC) Performance League Table.

11.4 Carbon Emissions.

We have put plans in place to reduce carbon emissions and improve our environmental sustainability. Over the next 10 years we expect to save £287,000 as a result of these measures.



Our measured greenhouse gas emissions have reduced by 0,365 tonnes since 2010/11. We recover or recycle 257 tonnes of waste, which is 17% of the total waste we produce. Our expenditure on waste has reduced from £609k in 2010/11 to £593k in 2011/12.

The domestic waste contract includes a clause to require recycling and it is very pleasing to report that approximately 75% of the Trust's domestic waste is now recycled. Work is on-going to adopt new ways to recycle other waste streams such as food and glass and these are schemes that will be adopted in 2012/13

Collection and disposal of clinical waste is currently undergoing a tender exercise and again, we will be looking to increase the recycled component. Technology is now available to recycle 'offensive waste' – and we will be looking to work in partnership with the new Contractor to develop ways of segregating this waste which will also reduce disposal costs.

The NHS places a substantial burden on the transport infrastructure, whether through patient, clinician or other business activity. This generates an impact on air quality and greenhouse gas emissions. Our organisation has a Sustainable Transport Plan and we recognise through this plan that it is important that we consider what steps are appropriate to reduce or change travel patterns.

Having an up to date Sustainable Development Management plan is a good way to ensure that an NHS organisation fulfils its commitment to conducting all aspects of its activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to develop a Sustainable Development Management plan. The Trust's full Sustainability and Carbon Management Strategy and the Action Plan were approved by the Board in November 2011.

11.5 Examples of good practice

There are many examples of good practice across the Trust, including:

- combined heat and power,
- new energy controls at PRH,
- energy efficient lighting,
- new windows at RSH ward block,
- car-sharing software for staff,
- additional cycle storage,
- tax-friendly cycle purchase,
- partnership working with Shropshire Council to promote cycling,
- excellent public transport links to the main sites,
- recycling of domestic waste,
- plans to recycle some clinical waste and also food waste from kitchens and League of Friends
- adoption of low-energy lighting and ventilation strategies in the new Cancer Centre, and
- consideration of renewable energy technologies for the new building at PRH.

Putting Patients First



Section 12: Delivering a Successful NHS Foundation Trust

- 12.1 Agreeing our trajectory to authorisation
- 12.2 The next steps
- 12.3 Key Milestones
- 12.4 Our FT membership

12.1 Agreeing our trajectory to authorisation

At the beginning of **2011/12**, the Trust refreshed and revised its plans for authorisation as an NHS Foundation Trust (FT) application. This built on the agreement of a detailed Tripartite Formal Agreement (TFA) between the Trust, SHA and Department of Health to ensure FT authorisation in line with the Government's deadline of 2014. The TFA set out the following milestones and key activities for the Trust's FT trajectory:

Table 12.1a – TFA milestones for 2011/12

Date	Milestone
Mar 2011	Reconfiguration of services proposal approved by Trust Board
Jun 2011	CIP for 2011/12-2013/14 outline in place. Formal review of the Trust's financial position and Cost Improvement Programme
Jun 2011	Draft OBC for reconfiguration of services produced and approved by Trust Board
Sep 2011	Board Development Plan agreed and approved by Trust Board
Sep 2011	Monthly profile run rate achieved
Dec 2011	3-5 year rolling recurrent CIP agreed
Jan 2012	Improved performance position achieved
Mar 2012	Quality Improvement Strategy completed
Mar/Apr 2012	First draft Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) completed
Mar/Apr 2012	Full Business Case (FBC) for Reconfiguration of Services approved by Trust Board

Since this agreement, a Single Operating Model has been adopted nationally to standardise the way SHAs assess NHS Trusts and give assurance to the Department of Health that aspirant Trusts are suitably fit to become Foundation Trusts. This model sets out a clear timetable for the Trust's authorisation journey, which is described later in this section.

12.2 The next steps

2012/13 will be a key year in the delivery of our FT trajectory. A Foundation Trust Programme Board is now fully in place, having been established in January 2012, chaired by the Trust Chairman. Monthly performance reporting is in place to the SHA via a new Provider Management Regime (PMR), which mirrors the way FTs routinely report clinical and financial performance to Monitor, the independent regulator of Foundation Trusts. A detailed project plan encompassing TFA and key FT milestones has also been developed which supports the assumptions for our proposed FT trajectory. This is monitored through the FT Programme Board which reports directly to the Trust Board.

Development of our five year **Integrated Business Plan (IBP)** is ongoing together with the **Long Term Financial Model (LTFM)**; the first draft iterations were submitted to the SHA in April 2012. The current focus is particularly on further development of the IBP, along with ensuring the delivery of TFA milestones which are: acquiring all-round approval for the full business case (FBC) for the reconfiguration of hospital services through the local health economy and; the independent assessment of our final **Quality Improvement Strategy** and **Quality Governance Framework** which was approved by the Trust Board in March.

Our **public consultation** on NHS Foundation Trust status took place in 2008. Since then, we have continued to communicate and engage widely in the development of our strategy and governance arrangements, ensuring that stakeholder groups have been kept informed and that our plans are built on the needs and aspirations of the communities we serve and the environment in which we operate. We have continued to seek views as part of structured "consultation refreshes" and during 2010/11 we also undertook an extensive public consultation on our service strategy as part of our Future Configuration of Hospital Services programme. The public and stakeholder engagement in this programme has continued through 2011/12. During 2012/13 we are launching our **Standing Stakeholder Conference**, chaired by the Trust Chairman, inviting a comprehensive range of local stakeholders to engage with us to consider the different aspects of our application, and influence our plans. Together these activities give us assurance that our plans remain grounded and up to date, and we will also be seeking counsel from the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin as to whether a further formal period of **public consultation** is required. If so, this would take place from June 2012. Outcomes of any consultation relating to our strategy or governance arrangements will be acted upon, with amendment being made to our FT Constitution where appropriate.

12.3 Key Milestones

We are also preparing for the emerging Single Operating Model (SOM) for provider development; a process constituting a 12 month SHA-led development phase of our FT application, for which we will be self assessing our Board's state of FT readiness through the **Board Governance Assurance Framework** (April-June), and analysing the state of the organisation's current and historic financial health through a process of independently assessed **historic due diligence** (June).

An independent assessment of **Quality Governance** arrangements will commence over the summer of 2012 before the SHA undertakes a readiness progress review of the Trust and holds a 'Board-to-Board' meeting to rigorously test members of our Board. Assessment and challenge our IBP/LTFM is ongoing from our first submission to the SHA, and work to develop plans will continue before final submission to the Department of Health in March 2013.

Table 12.3a – SOM milestones 2012/12

Application Process Milestones	Schedule 2012/13
Submission of draft IBP/LTFM linked to responsive review	April
FT Diagnostic / Readiness – 1. Initial Board interviews 2. initial Board observation 3. Initial commissioner interviews	May
Review of Trust submissions & preparation of readiness review pack	May
HDD Phase 1 starts	May/June
NHSFT Consultation starts - Launch public consultation - if required	June
Assess & challenge IBP/LTFM	July

12.4 Our FT membership

The Trust has already established a strong public and staff membership base, with now over 12,000 members. The **Foundation Trust membership office** continues to develop ways for members to become involved with the Trust via an ongoing programme of engagement activities for Foundation Trust members. We are also actively recruiting new members, particularly in under-represented areas.

Table 12.4a – Public membership representativeness

Public Constituency	Status
Gender	Male Female
Age (Years)	0 – 16
	17 - 21
	22+
Ethnicity	White
	Mixed
	Asian or Asian British
	Black or Black British
	Other
Socio-Economic Grouping	ABC1
	C2
	D
	E

Source: Capita Membership Services (Feb 2012)

In support of our transition to FT status, we are developing a **Membership Strategy** during 2012/13 which will set out our aspirations to strengthen and engage our communities in the new local accountability arrangements that form a key element of Foundation Trust governance and delivery. We have already exceeded our initial target of a public membership of 1% of our catchment area, and we now aspire to achieve a 2% membership (or more than 10,000 public members). This will ensure greater involvement and representation of our local community in the work of the Trust. An identified gap in our Foundation Trust membership is the under representation of young people aged between 16-21 years old. The membership office continues to work with local colleges and schools to look at ways to engage young people

with the work of the Trust, the most popular of which have been '*Behind The Scenes*' tours aimed at recruiting young members and offering volunteer opportunities.

Engaging our members

The Trust currently produces and sends a quarterly newsletter to all of its Foundation Trust public membership as well as to over 100 partner organisations. **A Healthier Future** newsletter contains information about developments and services provided by the Trust and also ways that members can become involved or attend Member events such as *health lectures*. Within recent editions of the magazine we have also had an insert of '*Looking to the Future*' which gives an update on the Trust's plans for reconfiguring services, and ways that members can become involved including; joining focus groups/workshops and attending public briefing sessions.

As we move towards authorisation we will be focusing on encouraging public and staff members to come forward for election as Public and Staff Governors, and then building strengthened member engagement between Governors and their constituencies.

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Section 13: Declarations



13.1 Provider Management Regime

As highlighted in section 8, the NHS Midlands and East Strategic Health Authority Cluster (SHA) introduced a Provider Management Regime (PMR) from January 2012. As well as completion of the templates for governance, finance, contractual risk and quality, there is a requirement for Board sign-off of a number of assurance statements. The Board confirmed full compliance position at the end of 2011/12 as set out on the right.

For the period highlighted, the Board has confirmed compliance with the necessary assurance statements and expects to continue doing so throughout 2012/13. If an assessment of non-compliance is made for any of the statements in-year, detailed plans to address this will be provided to the SHA – and monitored by the Trust's Board – at that time.

Monitor has published a revised (and draft) set of assurance statements for Foundation Trusts. These are similar to those contained with the PMR, other than those that relate specifically to issues regarding compliance with Authorisation. The Trust will consider if both sets of assurance statements need to be completed and approved by the Board on a regular basis and, if so, will ensure systems are in place to do so.

The Monitor assurance statements are attached at Appendix D

For each statement, the Board is asked to confirm the following:		Jan-12	Feb-12	Mar-12
For CLINICAL QUALITY, that:		Response	Response	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓	✓	✓
If the Trust Board is unable to make the above statement, the Board must:				
2	Be satisfied that, to the best of its knowledge and using its own processes (supported by CQC information and including any further metrics it chooses to adopt), its Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.			
3	Be satisfied that, to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the CQC's registration requirements			
4	Certify it is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the NHS foundation trust have met the relevant registration and revalidation requirements.			
5	Be satisfied that the Trust is embedding patient experience into the service design, improvement and delivery cycle.			
For SERVICE PERFORMANCE, that:		Response	Response	Response
6	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2011/12.	✓	✓	✓
For RISK MANAGEMENT PROCESSES, that:		Response	Response	Response
7	Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner	✓	✓	✓
8	All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	✓	✓	✓
9	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓	✓	✓
10	A Statement of Internal Control ("SIC") is in place, and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk)	✓	✓	✓
11	The trust has achieved a minimum of Level 2 performance against the key requirements of the Department of Health's Information Governance Toolkit	✓	✓	✓
For COMPLIANCE WITH THE NHS CONSTITUTION, that:		Response	Response	Response
12	The Board is assured that the trust will, at all times, have regard to the NHS constitution	✓	✓	✓
For BOARD, ROLES, STRUCTURES AND CAPACITY, that:		Response	Response	Response
13	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓	✓	✓
14	The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	✓	✓	✓
15	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓	✓	✓
16	The management team have the capability and experience necessary to deliver the annual plan	✓	✓	✓
17	The management structure in place is adequate to deliver the annual plan objectives for the next three years.	✓	✓	✓
Signed on behalf of the Trust:		Date	Date	Date
CEO		28/02/2012	30/03/2012	26/04/2012
Chair		28/02/2012	30/03/2012	26/04/2012

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Appendices



